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# Psychotherapy Reviewed

By E. J. Alexander, M.D.
Detroit, Michigan

THE TERM psychotherapy can be considered to include all the beneficial effects achieved by the personal influence of the physician. The purpose of this paper is to present the steps in psychotherapy in the order in which they ordinarily need to be employed by the general practitioner, with special attention to the common errors made at each step. These will be discussed under four headings: examination, reassurance, explanation, and therapeutic guidance.

## Examination

Diagnosis must always precede intelligent treatment, and that means a medical history and clinical examination adequate to the problem presented by the individual patient. No conscientious physician neglects these procedures in any case; but the busy general practitioner can, without sacrificing accuracy, make the diagnosis in the majority of his cases with a history and examination that are very brief and to the point. Usually, the diagnosis of psychoneurosis can also be made accurately with similar speed; the danger of an experienced physician overlooking a serious organic disorder is not very great, and if something important were overlooked, an alert doctor would probably be able to correct the error by continued observation and re-examination before serious harm could be done. Nevertheless, short-cuts in clinical examination constitute an error in the management of a psychoneurotic patient for this reason: the examination not only serves to establish the diagnosis but also constitutes the first step in treatment. When the patient observes that the examination is done conscientiously and carefully, he can believe that the doctor will take a sincere interest in his case—the first step in establishment of rapport has been taken. Furthermore, the patient's knowledge that his clinical examination has been thorough will permit him to believe, later, that the doctor knows what he is talking about when reassurance is begun.

Therefore, if time does not permit a thorough examination at first contact with the apparently psychoneurotic patient, the doctor's first step should be to arrange a time for that thorough clinical examination. When that has been completed, psychotherapy will already have begun.

## Reassurance

A major function of the good physician is to allay fear. Obviously, it is often the patient's apprehension about what his symptoms may mean, rather than the severity of the symptoms themselves, which causes him to consult the doctor at all. The mere presence of the physician at the scene of a medical emergency often does more to soothe the patient and take care of the situation than do the treatments administered. And yet it too often happens that the doctor, in dealing with a psychoneurotic patient, causes more fear than he quiets. An unethical practitioner may do it deliberately, in order to sell the patient an expensive "treatment" procedure; but because there is pathological anxiety present, in one form or another, in every psychoneurosis, the most honest and ethical doctor may also do it, unwittingly, by "quibbling."

By the term quibbling, I refer to the remarkable reluctance which exists on the part of many physicians to tell the patient the simple truth, that his

From the Department of Medicine, Division of Neuropsychiatry, Henry Ford Hospital, Detroit, Michigan.

illness is psychiatric or emotional. To be sure, it is probably wise to avoid using psychiatric diagnostic terms, such as psychoneurosis, to the patient, simply because the terms are too much misunderstood; but there is no reason why the doctor cannot state definitely and precisely, "You have no organic (physical) disease; your symptoms are due to nervousness, or to emotional factors." Although the doctor does say something like that, too often (perhaps in an attempt to avoid explaining what "nervousness" and "emotional factors" are) he quibbles. He remarks that he has found something like high blood pressure, or rapid heart rate, or anemia, that "may contribute" to the symptoms. Under these circumstances, the patient's fear about the brain tumor or cancer he thought he had may be quieted, but there has been no real reassurance, for the doctor has simply given the patient something more concrete and specific to serve as a focal point for his anxiety.

The doctor can avoid quibbling if he will avoid the use of the phrase "*may* contribute." He is the doctor; he is the one to state whether or not a given somatic finding does contribute—and if so, how much—to the general symptomatology of which the patient complains. His honest opinion is all that is wanted. However, we should not forget, too, that even a doctor can sometimes think he is being honest, when actually on reflection he would know that he is merely avoiding a troublesome task by wishful thinking and rationalization. The patient may have two separate and distinct conditions, an emotional illness and a physical one, and the doctor who is too "somatic-minded" will elect to treat the minor physical illness and simply ignore the major emotional illness: "You are nervous, yes; and you don't sleep well at night; but you have a chronic cervicitis. Let's cauterize that and see if you don't feel better." Of course, a good doctor will treat everything the patient needs treated; but it is not our custom, if a patient comes in complaining of urinary retention, to ignore the prostate and sell him instead an operation for removal of his cataracts. We concentrate on the chief complaint or the more serious condition first. When the chief complaints are due to emotional illness, however, some justification for this shift of emphasis by the doctor is to be found in the well-established rule that putting the patient into as good physical condition as possible is itself treatment, to some extent, for the psychoneurosis. However, rationalization and wishful thinking based on that rule can lead to errors in judgment almost as glaring as this: to cure ringworm between the toes might, by removing one of the infections the body is fighting, perhaps leave the body with more resistance to fight pneumonia; and to cure ringworm between the toes might stop an itching that was one more annoyance to a nervous person, and thus might help him. Such indirect and inefficient ways to cure pneumonia would constitute serious neglect of the patient; such methods based on rationalization rather than serious thought constitute equally serious neglect of the psychoneurotic patient. While the doctor is correcting the minor physical defects, the psychoneurosis, day by day, is becoming more ingrained, and the patient's insight into his emotional life is becoming more and more obscured and confused by the new issues which absorb the attention of the doctor.

If reassurance is properly done—that is, the patient is thoroughly convinced that he does not have wrong with him what he feared he had—it is sometimes sufficient to "cure" him. This is how it works: The patient has not had his basic symptoms modified particularly—for example, pain in the chest or dizziness—but the meaning he had conjured up for his symptom, due to the anxious trends in his personality, has been eradicated; he no longer has a reason to fear "heart trouble" in the one instance, or "stroke" in the other. The state of panic from which he suffered, as long as those serious disorders seemed imminent, is relieved, and the secondary disturbances of physiological function due to that fear are also relieved. He may then feel well enough so that no further psychotherapy is needed.

### Explanation

If a psychoneurosis has become well established, however, mere reassurance is not often adequate to remove the symptoms for very long. The doctor may have given the patient a great deal of reassurance and comfort by stating, in an authoritative and self-confident way, something like this: "You're 100 per cent; your heart, blood pressure, and all your other organs are perfectly normal. There's nothing at all wrong with you. Go home and forget all about your nervousness." The comfort the patient gets lasts only a few days, however; then he is likely to notice that some symptoms remain. Having been told there is "nothing" wrong with him, but knowing that he is "nervous,"

his ruminations may go something like this (not because his thinking is logical, but simply because he is an anxious person): "Could I be imagining all this? The doctor said there's nothing wrong with me, but I feel so odd; and he did say I was nervous. I've heard that nervous people sometimes go insane. Dear me, if I'm imagining all these things I feel, then I must be insane."

Such ruminations and anxieties can be prevented if the doctor will take the time to tell the patient not only what is not wrong with him (reassurance), but also to tell him what is wrong with him—emotional illness. The doctor should explain to the patient how fear and other emotions affect the functioning of the body; he should illustrate with common every-day examples, such as these: embarrassment causes blushing, fear causes tachycardia, anger raises blood pressure, disgust may cause vomiting, grief causes a feeling of a lump in the throat, et cetera.

The main reason why doctors so often neglect that explanation, I think, is because they don't quite believe in it themselves. The doctor, of course, has studied all about the autonomic nervous system, and knows how it controls the function of every organ; but at the same time, he may like to believe that one should not "allow himself to be bothered" by an emotion, and that one should "control his feelings." If so, the doctor has this blind spot in his memory: he has forgotten that the other name the autonomic nervous system bears is the "involuntary" nervous system. By definition, it is not under the control of what we call our will power. The command so often given to the emotionally ill person, "control yourself," may apply within limits to that person's voluntary nervous system: feeling inclined to run from danger, he may stand to meet it; feeling inclined to strike another person in anger, he may instead turn the other cheek; feeling ill at ease or depressed, he may conceal his discomfort from others. However, it is foolish indeed to expect that command, "control yourself," to make any change in the function of the involuntary nervous system. No one of us can speed up or slow down his pulse, blush or cease from blushing, secrete gastric juice or stop its secretion, simply by willing it. Most nervous patients urgently need to meet a doctor who can explain to them that "will power" is not the way to relieve the symptoms of emotional tension, and that to conceal how he feels does not change how he feels. True, he may need occasionally to be encouraged to do his daily activities in spite of how he feels, but the doctor should not imply directly or indirectly that such grim carrying-on is the main principle of psychotherapy.

The three steps in psychiatric first aid so far presented—examination, reassurance and explanation—are so simple and obvious that every doctor can do them, and many patients can be adequately controlled by this program. Several repetitions of reassurance and explanation may be required before the patient fully grasps and assimilates the ideas presented, but when he does understand the nature of his symptoms, he can then to some extent reassure himself. He may feel his heart pound, or feel a pressure in his head, and yet remain relatively calm about it.

### Therapeutic Guidance

It is at the next step in the psychotherapeutic process that most doctors begin to get confused and a little uneasy. That step begins when the patient first asks a question worded something like this: "I understand now that I am physically sound, and that my symptoms are due to fear or some other emotion. But what caused me to become afraid in the first place? What am I still afraid of, enough to make these odd waves of feelings that still pass over me from time to time? My nervousness—that is, my emotional tension—causes my physical symptoms, yes—but what causes my nervousness?"

In order to answer that question, the patient must develop insight, a self-knowledge that he at present does not have. We psychiatrists tell the doctor that he develops that insight in the patient by listening to the patient's life story, but that is not an entirely adequate description of the process of insight psychotherapy. After the doctor knows all about mother and father and Uncle Joe, about bed-wetting and nightmares, about childhood and adult sexual indiscretions, about marriage, childbirth, and economic stresses, and about the fact that mother-in-law is a most unpleasant person, what then? What does it all mean to the doctor? Is it more important that the patient had an alcoholic father who beat the child three times a week twenty-five years ago, or that the patient is right now $300 in debt? I will try to clarify that by discussing, under three subheadings, what the doctor should learn from the story of the patient's life, and how he uses that information for therapeutic guidance:

1. The life situation: what facts confronted the patient at the time of the development of his emotional symptoms, and what facts now confront him.

2. His personality formulation: what his life situation means to him, in terms of the attitudes he has demonstrated in action throughout his life.

3. The development of insight: understanding the psychological reasons why the symptoms developed.

### The Life Situation

When a patient is permitted by the physician to talk about his personal life as well as about his symptoms, it not infrequently happens that a very circumstantial account of his present life problems is forthcoming. The patient seems to interpret the doctor's willingness to listen as an implied promise that the doctor will solve the problems of the patient. It is as if the patient says, "You are so much wiser than I am, Doctor; tell me what to do." Flattered by this attitude, and not being clear in his own mind concerning his real function in psychotherapy, the doctor may accept the role the patient is offering to him. He may accept the responsibility for solving the real life problems facing the patient, by advising changes in this or that element in the external situation. Usually this is an error in handling the patient. Although situational modification is a form of psychotherapy that does occasionally have distinct usefulness, it is not by any means the cornerstone of psychotherapy. In child psychiatry, by changing the environment or situation the child must face, very good results can be obtained; and, as a temporary expedient in adult psychiatry, the scaling down of the responsibilities of the patient may be desirable, providing that this is coupled with a type of psychotherapy designed to make the patient grow in emotional maturity until he can meet full adult responsibilities with adult self-sufficiency, and make his necessary decisions on his own initiative. No doctor can permanently undertake to be peacemaker, or friend in need, or clever Mr. Fixit for his patient.

Let me illustrate the sort of merry-go-round that usually develops when the concept of psychotherapy the doctor has is limited to the idea of situational readjustment. The doctor may ask, "What do you worry about?" That may set off a harangue that lasts interminably, but which can be summed up, let us say, by, "My mother-in-law is an unholy terror, and she upsets my emotional balance." The doctor may then say something like, "Your physical symptoms are due to your emotions, in this case anger; your mother-in-law makes you angry; therefore, in order to cure your symptoms, we must do something about changing the mother-in-law situation." The doctor then thinks of every solution he can, but to every suggestion the patient raises a very practical, valid, insurmountable obstacle. Finally the doctor realizes that, after all, the patient is not unintelligent, and if there were any very practical way to get rid of or circumvent the mother-in-law, he would have done it long ago without ever consulting a doctor. Then the doctor may say, "Well, you will just have to stop getting angry at her." To this the patient says, "I do try my best, Doc, but I can't. I'll bet if you tried living with her, you'd get nervous too!" The psychotherapy dwindles down and ends with the doctor saying rather helplessly, "Well, John, I've told you your trouble; your mother-in-law makes your head ache; and so from here on, it's up to you." The doctor has made one slight mistake—it wasn't the doctor but John himself who made that diagnosis, and so the doctor hasn't really "found" the trouble after all.

The psychotherapy proceeds no better, concerning the patient's life situation, when the discussion takes this turn: The doctor asks, "What do you worry about, what are you afraid of?" The patient responds with, "Not a thing in the world except the way I feel. I have nothing to worry about and nothing to be nervous about." That creates a complete impasse for many a doctor. He has contended to the patient that the symptoms are due to nervousness, and the patient contends that there can be no cause for the nervousness except the symptoms. Soon the doctor becomes a little angry because he thinks the patient is concealing something, and the patient feels worse because he senses that the doctor is angry with him. Psychotherapy has ended.

In summary, if the doctor can modify the patient's life situation favorably, he should do so, but that is not his primary purpose in listening to the patient tell his life story. Instead, the important aim of the doctor is to learn what changes occurred, or were about to occur, in the emotional life of the patient at the time the nervous symptoms first appeared. However unimportant the patient considers those situational changes, they should be noted carefully, in order that they may

later be correlated with the attitudes that make up the personality of the patient.

### The Personality Formulation

Although the life situation confronting the psychoneurotic patient, more times than not, cannot be adjusted to his wishes, all is not therefore lost; perhaps the attitudes of the patient toward his situation can be changed. Since, in any given situation, no two people ever think, feel, or act exactly alike, it follows that situations and attitudes must always be considered reciprocally—one has no meaning without the other. The approach of marriage may be to one girl a time of great bliss; to another it may represent a desperate attempt to seize the only man available to her before she reaches the fateful age of thirty. One prospective father may swell with pride; another may be disturbed by the fear that the coming infant will be a rival for the affections of the only woman who has ever paid any attention to him. A promotion to one employe may mean a way to balance his budget; to another it may mean a quaking fear of the added responsibility or of the jealousy of his former associates. One speech-maker may enjoy the chance to strut; another may be paralyzed by fear. To one person a glass of water is half-full, and to another it appears half-empty.

The doctor learns to know what attitudes make up the personality of the patient during the time the patient tells his life history. As he tells how he has reacted to numerous situations in the past, he is indirectly indicating how he thought and felt in those situations. His habits of thinking, feeling, and being moved to act are the psychological, or inner, realities (as distinguished from the external realities of his life situation) which we may group under the general term "attitudes"; and, taken all together, these make up his personality formulation. When the doctor begins to understand the patient's personality, the doctor will then be able to surmise what that particular person must have thought, how he must have felt, and how he must have been moved to behave in the life situation facing him at the time he became ill. The doctor's correlation of those inner realities with the external realities permits him to begin to understand what problem the psychoneurotic symptoms were developed to solve; he knows even better than the patient what is "bothering" him.

The common error in psychotherapy that occurs at this stage comes about because the doctor proceeds too rapidly to present his interpretations to the patient. The patient invariably then begins to feel that the doctor is criticizing him, no matter how tactfully and kindly the doctor speaks. Admittedly, the doctor is trying to get the patient to change himself, which seems almost the same as finding fault with the patient as he is. There is a difference, however. Psychotherapy consists of letting the patient find his own "faults," the inner psychic realities that cause him pain to contemplate—that is, thoughts, feelings, and impulses that are inconsistent with his concept of an acceptable personality. The doctor's function is to provide the emotional climate in which this painful self-knowledge and insight can occur, and to point the directions in which the patient shall search himself. Although any person will admit to the general proposition that he is something less than perfect, he nevertheless suffers more or less pain whenever one of his imperfections and inefficiencies is specifically pointed out to him. There is a "resistance" to that self-knowledge; and it works out, as a general rule in psychotherapy, that the patient cannot gain important self-knowledge until an emotional compensation for the pain is available. That compensation is to be found in the total acceptance and understanding which the doctor gives him, in the rapport which exists between doctor and patient.

Mere knowledge of that principle is not enough, however. Errors such as the one just mentioned —trying to force insight upon the patient before he is ready for it—come about more often not because of lack of knowledge of the theories of psychological medicine on the part of the doctor, but because the doctor is not adequately prepared emotionally to do insight psychotherapy. By gesture, tone of voice, or direct statement, the doctor is certain to betray his own feelings toward the patient many times during their meetings; and if those feelings are not the right ones, the therapeutic results will be poor. The doctor's ability to remain understanding, friendly, and non-critical toward the patient is the emotional force which overcomes the resistance of the patient to the painful insight which is curative. In order to maintain that attitude, the doctor must possess tact, patience, and human warmth, and he must have an interest in psychological medicine and adequate time that he can give unreluctantly to such patients. It is not hard for the doctor to decide whether or not

he has those attributes. However, it is much harder for him to be aware of certain other attitudes within himself that may interfere with his efficiency in psychotherapy. To illustrate the point, I will discuss two such attitudes that seem particularly important to me.

The doctor must learn to avoid our habitual learned tendency to categorize behavior and thinking as either "good" or "bad." Instinct, in man as well as in animals, is dynamic, forceful, moving, but is essentially independent of morals. Within all of us, impulses arise from our instinctual nature that move us toward selfish, sensual, lazy, cruel, aggressive, dishonest, adulterous and other "bad" behavior; but we are also moved at other times, by the same instinctual force, toward unselfish, self-sacrificial, tender, loving, protective, ambitious, strong, kindly, faithful, and other "good" behavior. The force is as natural as rain, and whether its effects are "good" or "bad" depends entirely upon a person's point of view toward it and the usage he makes of it. Before a person can be thoroughly aware of the implications of this amorality of instinct, he usually needs to have studied carefully the effects of instinct upon his own thinking, feeling, and behavior. Fortified with that self-understanding, he is then protected against feeling (and unwittingly betraying to the patient) repugnance and squeamishness when his patient first comes face to face with the "bad" side of the instincts within himself.

A second insight the doctor needs is into the workings within himself of the instinct to power. This is an inner compulsion to exhibit one's own strength, ability, skill, intelligence, and power, at the expense of whoever is most conveniently available. We have already given an example of this force at work, in the doctor who tried to force insight upon the patient too soon. He knew better, and yet he behaved as if he considered his task as therapist to be the pointing out of the patient's faults. He did not accomplish the aim he consciously intended, of giving the patient insight; but he did "succeed" in making the patient feel humiliated, criticized, and in the wrong. Therein is the clue to what went wrong with the therapy. The doctor's own emotions tricked him into putting the patient in a position of inferiority, or, worded the other way, into putting the doctor in a position of superiority.

The workings of this force need to be considered very carefully by the general practitioner who wishes to add insight psychotherapy to his treatment methods. Doctors in general are accustomed to expect their patients to obey orders without question, and to expect that the infirmities shall yield promptly, most of the time, to the treatments administered. The doctor daily seems to demonstrate to himself that he has power over the patient and power over disease. This is an extraordinarily subtle temptation to yield oneself to the power "devil," and forget humility; and it is, I think, the main reason why doctors, as a group, are more resistant to the teachings of depth psychology than are most other intelligent and educated persons. They want nothing to do with it, because it demands of them that they give up the illusion of being in "control" of the medical situation. To be sure, the doctor usually does retain his humility, perhaps by remembering with Ambrose Pare that he merely dresses the wound while God heals it, or by remembering that the man-made improvements on the healing power of nature which he uses, such as surgery, penicillin, and diphtheria antitoxin, are merely his heritage from the accumulated efforts and knowledge of thousands of people. If his pride does become too great, the course of events will usually chasten it in a painful way—having assumed the full responsibility for the good effects his treatments have, he may come to suffer a compulsive intensity and serious-mindedness in his practice that takes away his pleasure in it, or he may become plagued by a sense of inadequacy, failure, and guilt because he also must then accept the full responsibility for the times his treatments fail to give a perfect result. But that discussion refers to pride and humility as general, long-term attitudes; it is more pertinent for the doctor undertaking self-appraisal, before doing insight psychotherapy, to ask himself to what extent he has an inner need for the day-to-day subservience, obedience, and "worship" of his patients. It may help him answer that question of himself if I give a few examples of how it works. The doctor makes light of the patient's symptoms, saying, "Ah, that wouldn't bother me (—but since it does bother you, I must be stronger than you are—)." The doctor scoffs at the patient's inability to see the "common sense" solution to his problems and to act "reasonably." "Why, of course, anyone with common sense (—such as I have and you obviously don't have—) would do thus and so about it." The doctor is angry when the resistance of the patient makes him reject an

explanation the doctor has offered. "Of course, I know there is such a thing as 'resistance,' but. . . (—it should not be as strong as your respect for my great psychological knowledge—)." The doctor is angry because the symptoms of the patient do not disappear as rapidly as he wishes or expects. "(—I am a very clever doctor and I have treated you perfectly and it is therefore your own perversity that keeps you from getting well—)."

We may leave this subject with the comment that to do successful insight psychotherapy, the doctor must understand himself at least as well as he understands what is going on in the patient's psyche.

### The Development of Insight

I will recapitulate what the doctor has learned by now about the patient: by making a correlation between the patient's life situation (the external realities) and his personality—as demonstrated by his habits of thinking, feeling, and acting in the past—the doctor is able to surmise how the patient must have thought, felt, or been impelled to act at the time the symptoms developed. The final task consists in leading the patient to an awareness that he did in fact think, or feel, or have an impulse to act in a certain way, and that the symptoms he has developed constitute a solution, although an inefficient one, for the conflict between that inner psychic reality (the thought, feeling, or impulse) and the external realities of the life situation. That awareness becomes possible, not through reasoning and argument by the doctor, but by a train of thought association that cannot be foreseen by the doctor. All of us have had the experience of having our memory stimulated by another person, concerning a fact in the past; although it sounds vaguely familiar, it does not have force until, of a sudden, some trivial detail "clicks," and we can say, "Yes, now I remember. Your speaking of the taxi reminded me that I noticed that the taxi driver's hands were blue with the cold and I wondered why he didn't wear gloves." Something similar occurs in insight psychotherapy. Hypnotism, the interpretation of dreams, and discussions with the patient under the partial influence of a hypnotic drug are methods the psychiatrist can use sometimes to learn more rapidly the particular associative links which the patient needs as a key to his memory, but the same results can be obtained by urging the patient in the fully conscious state for his thought associations to a particular theme that seems significant to the doctor.

When psychiatrists say that such insight, once the patient does acquire it, is curative, it usually leaves the non-psychiatrist shaking his head doubtfully. How can self-knowledge cure anything except self-deception? That's exactly right—that's what it does cure. To be sure, the problem which the patient originally solved by self-deception is usually still present, but it can then be faced by the ordinary methods we all use to meet our unhappy moments. The patient may still be unhappy, but he won't be sick.

It is a fundamental concept in modern dynamic psychology that man does not "know" his own motives nearly as well as he likes to believe. Since that concept applies to normal persons too, it applies to the doctor; and the doctor is usually as "resistant" to accepting the concept, when it is first presented to him, as is any neurotic patient. I cannot attempt to overcome that resistance here and now by presenting all the details of psychopathology, but I do wish to say enough on this theme of self-deception to outline why it occurs and how it causes symptoms.

The self-deception comes about because the patient experiences a certain thought, longing, or impulse which is too dangerous or guilty to entertain. He wants to act in a certain way—or more accurately, the life force within him, or his instinctual nature (the "id" in psychoanalytic terminology), "wants" him to act in a certain way—but he has learned to believe that if such action slipped out in word or deed, it would result in great danger to himself or great loss of the esteem of others. He is overwhelmed by the conflict between the taboo need on the one hand, and his need for security and/or affection on the other hand. As long as the taboo need makes itself known to him through thought, longing, or impulse, he feels fear, shame, or guilt. To rid himself of those unpleasant feelings, he tries to rid himself of the psychic fact—the thought, longing, or impulse—that has intruded itself unwanted by his personality but "wanted" by his instinctual nature. (To clarify this use of "want," the starving man does not "want" to be hungry, because it is painful, but the life force within him "wants" him to be fed and forces him by the pain of hunger and the thought of food to take some sort of action.) The patient tries not to think the fearful thought, not to want the shameful thing, not to do the guilty

act. He may be successful in putting the thought, the longing, or the impulse "out of his mind"—that is, he may become unaware of the fact that it ever existed. In psychiatric terminology, it has become unconscious. But the fact that he has become unaware of those particular thoughts, longings, or impulses has in no way lessened the force of the instinctual need originally responsible for them. Awareness of the need may not exist, but the need itself does. The behavior (including, under that term, action of the autonomic nervous system as well as action of the voluntary nervous system) developed to secure partial, indirect, or substitute satisfaction of the need, while preserving unawareness of the taboo part of the need, constitutes the psychoneurotic symptomatology. The "mental mechanisms" (such as repression, regression, symbolization, rationalization, displacement, and others), whereby the dual aim of need satisfaction and defense against awareness is accomplished, may be studied in any text on psychopathology. It is only necessary to note here, again, the reasons why there is "resistance" to giving up the symptoms. In the first place, fear, shame, or guilt of almost overwhelming degree must be experienced as awareness of the taboo psychic material is approached; and so the awareness must be approached slowly, with security, tolerance, and understanding being constantly provided by the physician. In the second place, the substitute satisfaction of the instinctual need, inefficient and painful as it may be, is still a greater force upon the patient than is the prospect of no satisfaction at all; and so the patient cannot give up his "secondary gain" until the way is open for him to seek his instinctual satisfactions, with some chance of success, in a more acceptable way.

It is easier to show by some simple examples how self-deception makes a person ill, than it is to show how self-knowledge makes him well. For instance, a girl is blessed with normally functioning glands, but she long ago learned that sex activities or sex thoughts of any kind were extremely dangerous. They would mean severe censure from her parents, or punishment; and the degree of fear she feels is determined not so much by the reality of the punishments her parents would actually use, but rather by her conception of the punishment which would ensue. This conception is subject to fantastic exaggeration and misinterpretation in an immature mind. In order to avoid her fear, she keeps from sex activity; in order to avoid temptation in that direction, she avoids sex thoughts; in order to keep such thoughts from being aroused, she avoids contact with boys; to avoid this, she gives up thinking of marriage; to avoid this, she avoids seeing married people; to avoid this, she stays fearfully at home, perhaps being panic-stricken except when mother is there with her. Yet no matter how thoroughly she secludes herself, she cannot stop her glands from functioning. The stronger the biological drive and the more dangerous its satisfaction appeared to her, the more numerous the thoughts, longings, and impulses she must try to push out of her mind; and when adult living begins to force her to walk a little beyond the psychic barriers she has erected, she then feels fear. It is not her life situation (the fact that sexual experience is a normal and natural part of adult living), nor is it the biological drive within her toward mating, but rather it is her self-deception, her attempt to conceal from herself that this biological drive exists, which causes her fear. Because she is unable, through acquired fear, to think about a normal husband-wife relationship and must deceive herself about wanting it, about the only satisfaction her need for affection can find is in regression—clinging like an infant to her mother.

As another example, we may think of a woman who is acting as a nurse to her invalid father. She may be doing that job out of a deep and sincere love for him, or she may be doing it so that he will leave her $10,000 in his will. If the motive is pure, 100 per cent love, no matter how hard she works at it, her physical fatigue will not be complicated by nervous fatigue, because she will receive an emotional satisfaction from the work itself. However, if her motive is truly avarice, and she conceals this fact from herself, believing that her work is a labor of love, she will find herself becoming strangely fatigued, tense, irritable at the task. She will force herself to work at it more diligently and conscientiously than is really necessary, and yet will feel a continual sense of guilt that she is really not doing enough for him. Eventually her symptoms reach the point where there is some neglect of the old man, or her irritability causes her to say bitter and cruel things to him, which then further increases her sense of guilt and her nervousness. Eventually she consults a doctor, who probably agrees with her that she "can't" do the job of nursing the old man, because of her nervousness, and he advises a situational

readjustment which relieves her of the burden. The truth of the matter is that she unconsciously did not "want" to nurse him, but she does "want" the $10,000; and therefore, any situational readjustment the doctor suggests which endangers that legacy is not going to satisfy the patient and relieve her nervousness. Let us consider how the matter would go if the woman honestly could admit to herself that she did not love her father, as she had been taught she "should," but was moved instead by love for his bank account. She might then find the job tiring, but it would not be a source of conflict which would take her to the doctor. She would keep on doing it if it was worth the money; and if it was not she would tell the old gentleman with perfect equanimity to hire himself a nurse and cease bothering her. It is not the situation (the invalid father) nor the psychic fact (her avarice and lack of love for her father), but it is her self-deception about the psychic fact which makes her uncomfortable.

The final error which requires consideration is this: the doctor is not quite specific enough in his own mind concerning his goals in therapy for a particular patient. In a brief way, I will outline here three levels of psychotherapy:

*Supportive Psychotherapy.*—The doctor may resolve that the best he can do is to help the patient hold on to his present partially decompensated state, which has apparently characterized him for years. He resolves to give the patient emotional support (reassurance, tolerance, understanding) and guidance. This is good therapy, for it helps the patient to feel more comfortable, and it protects him from complete helplessness in situations he is not strong enough to meet alone, but the doctor should recognize that this is not really insight psychotherapy. It implies that the doctor has decided that, for one reason or another, it is not practical for this patient to reach a state of emotional self-sufficiency; he cannot do without someone to be his counsellor, confessor, and understanding friend in need, and the doctor takes over that function. This is the type of psychotherapy for which the old-time family physician was justly famous. He had one advantage over his modern successor—he did not have to listen to his patients so much, because he already knew them intimately. With that one modification—taking time to get the whole story—the modern general practitioner can do just as well. Obviously advice, situational adjustment, and symptomatic medication hold a much larger part in this type of psychotherapy than they do in insight psychotherapy. The doctor must also play the very important role of protecting his patient from unnecessary operations and all forms of expensive charlatanism.

*Brief Insight Psychotherapy.*—The doctor may decide to give the patient insight into a relatively superficial conflict. This implies that the symptoms are relatively recent; that the patient has demonstrated a personality with good adjustment capacity to the requirements of adult living; that the doctor believes the insight necessary is one which constitutes a relatively slight offense against accepted social customs; and that the doctor believes the patient has good "ego strength." It is hard to define that term accurately, but the slang term "he can take it" is a good approximation. It means that the patient is able to accept unpleasant facts about himself, and see their truth readily, without being overwhelmed by shame or guilt. Under these circumstances, the doctor uses reassurance and explanation, listens to the patient's complete story, and supplements his information with direct questioning; then he proceeds to present directly to the patient his interpretations about what the patient has said, and his surmises about what the psychic material was which led to the symptoms. Of course, the doctor must present these in a tentative way, rather than as an established fact; and whether or not this procedure works depends not only upon the doctor's adeptness at making accurate interpretations and surmises, but also upon the resistance which exists to the particular insights which are necessary. If the procedure works, this "brief psychotherapy" (from one to ten or twenty treatment hours) is very gratifying both to doctor and patient. However, if the doctor's interpretations cannot be accepted as they are given, no harm is done if the doctor has been discreet, tactful, and tentative in his presentations. The doctor need not conclude that his interpretations are necessarily incorrect; it is more likely that it is the patient's resistance which constitutes the obstacle, and the length of psychotherapy will not be as brief as the doctor had hoped.

*Character Modification.*—All too often it becomes apparent that, although the symptoms are

of recent origin, they merely represent the final breakdown of an emotionally determined attitude which has existed for many years but is no longer tenable. An example of this is to be found in the psychologically determined depressions of the middle years of life. The headache or nervous indigestion of recent origin is seen to be related to the failure of a compulsive success-striving which has existed since earliest life; and while that attitude could pass as laudable ambition and initiative as long as new worlds were continually being conquered, it becomes sooner or later a goad which takes the joy out of living. The apparent symptoms which first bring the patient to the doctor are like the top of the iceberg—much lies hidden beneath the surface. To modify such emotionally determined attitudes which support the symptoms is a major undertaking. There is nothing brief about this, for these attitudes rest upon the same self-deception which later symptoms do, but the self-deceptions occurred at the time the attitudes were laid down, many years ago. These emotionally determined attitudes are defenses against awareness and partial satisfactions of psychic material which existed in an immature mind. Insight into these is the task undertaken by formal psychoanalysis. The beginner in psychotherapy would be unwise to attempt insight development at such depth; he needs voluntarily to restrict himself to working at the depth where he is himself comfortable.

### Summary

1. Examination establishes the clinical diagnosis and prepares the way for psychotherapy. The examination must be thorough.

2. Reassurance tells the patient what he doesn't have, and allays secondary fear—the fear of his symptoms. The doctor must take care not to raise new fears while he is quieting old ones.

3. Explanation further allays secondary fear by giving the patient enough understanding so that, to some extent, he can reassure himself. A failure at this step is usually caused because the doctor himself does not quite believe in the involuntary nature of the autonomic nervous system.

4. Insight psychotherapy begins when attention is directed to the patient's emotional life, and inner psychic experiences. From the material, the doctor learns about the life situation of the patient and about his personality formulations. By a correlation of these, the doctor gains preliminary insight into the patient's problem and learns in what direction to stimulate the thought associations of the patient.

5. Situational readjustment is sometimes helpful, but it is not the cornerstone of psychotherapy.

6. When evaluation of the personality of the patient is attempted, the errors which develop usually come about because the doctor does not understand his own personality workings adequately. The doctor must have not only the time for and an interest in psychological medicine, but also he must understand himself at least to the same depth to which he intends to understand his patient.

7. Insight, or self-knowledge, is curative because every psychoneurosis rests upon self-deception. Since not all patients are suitable subjects for the deepest insight, it is necessary that the doctor have clearly in mind his therapeutic goals for the particular patient.

## MSMS

### POLITICAL MEDICINE IN CALIFORNIA

For a third time, Governor Warren is advocating a compulsory health insurance program for California. In a message to the legislature January 3, he claimed that millions of people in California cannot pay for adequate medical care "without crippling their finances and without depriving themselves of other things that are needed to raise a good American family."

He urged legislative adoption of a system of "health insurance to which everyone contributes and through which everyone will receive benefits in time of sickness."

The program would be financed, in part, by compulsory payroll taxes, referred to as "contributions" imposed on employers and employes.

The existing Department of Employment and a newly created Health Service Authority would administer the act. This authority would include the director of public health as chairman, the chief executive officer of the Department of Employment, three physicians, two representatives of labor, two representatives of employers, and one dentist, the last eight members being appointed by the governor.

Each physician who participates in the program will presumably have to determine at his peril what is or is not a material fact. Failure to disclose by physicians and by others is also declared to be a misdemeanor, as is also willful violation of any rule or regulation promulgated or published to effectuate the program.

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### NEW OFFICERS

At the meeting of the Detroit Dermatological Society on May 18, 1949, the following officers were installed for the year 1949-50.

President—Dr. Frank Stiles, 2012 Olds Tower, Lansing 2, Michigan.

President-elect—Dr. Arthur E. Schiller, 2010 David Broderick Tower, Detroit 26, Michigan.

Secretary-Treasurer—Dr. Herbert H. Holman, 2010 David Broderick Tower, Detroit 26, Michigan.

Recorder—Dr. Hermann Pinkus, 12 East 4th Street, Monroe, Michigan.

# The Rise in Hospital Costs

By E. Dwight Barnett, M.D.

Detroit, Michigan

THE COST of hospital services has increased rapidly over the last ten years. It is questionable whether hospital cost has risen out of proportion to the cost of other desirable commodities and services. I do not believe it has. Those who complain about the high cost of hospital care have been known to budget stringently over a long period of time for an automobile costing twice what it did a decade ago. On the other hand, these same people have refused to provide for a service which would actually save their lives. The hospital bill always comes to these people at a time when they are least able to pay it.

Perhaps the most important factor responsible for rising hospital costs is an ever-increasing payroll. Payroll, once 40 per cent of the hospital dollar, now accounts for approximately 70 per cent. The old concept of an eleemosynary institution was that those who worked therein, in effect, made a contribution to charity and, therefore, could not expect compensation equal to that which could be obtained in industry. Today it is argued, and with logic, that a hospital, in the process of bestowing charity, should not create charities in the form of underpaid workers.

Whether this be actual public opinion or not, hospitals have been forced to substantially increase wages all along the line in order to maintain a foothold in the labor market. Orderlies, once paid $45.00 a month with maintenance, now have a starting salary of $150.00. Other employes in the hospital, as well as the technically trained and professionally trained, show a similar salary history.

Changing medical practice has also affected hospital costs. The public now realizes the beneficence of early ambulation, resulting in a shorter hospital stay. Yet the public has not been aware of the effect a shorter hospital stay has had on hospital costs. Hospital value received still means "room and board" to the average citizen. "Why should three days in a hospital cost sixty dollars, while the best hotel charges twenty?" he asks.

What is not realized is that the first few days of hospital care are the high cost days. During this short period the acutely ill patient may require all the facilities of the hospital. Highly trained personnel, working in expensively outfitted laboratories such as blood bank, hematology, bacteriology and serology, serve the patient, yet he is seldom aware of it. Additional personnel are called upon to administer a variety of costly medications.

When the practice of medicine progressed from the "little black bag" to the hospital, the cost of medical care increased. It further increased when the high cost hospital days could not be prorated to the lower cost convalescent days that followed. A high concentration of acutely ill patients in our hospitals today means they must bear full cost of the few days they are in the hospital.

Hospital educational programs, once thought to be a source of cheap labor, are actually financial liabilities, further increasing hospital costs. Student nurses once supplemented professional nursing to the extent that fewer registered nurses were required. Now, however, hospitals must hire a complete staff of nursing personnel as well as pay for the cost of nursing education. In addition to intern and nursing education, hospitals now find they must train a large variety of personnel to meet the ever-increasing demands of advancing medicine. Teaching hospitals unquestionably are high cost hospitals. Curtailing this vital activity would compromise the hospital's responsibility to its community.

In meeting the problem of rising costs, hospitals must receive additional income, whether it be from the patient (his life was saved, but the coffee was cold), government sources, or private philanthropy. However, this is not the whole answer. We must borrow the techniques of industry in effecting economies in the production of well patients.

A tremendous job lies ahead of us in the education of hospital personnel. Those professionally and technically trained, often considered poor managers, must be made dollar conscious. Lavish use of supplies and equipment does not insure adequate medical care—their economic use should not connote lower standards, the cry commonly heard. Hospitals like automobiles are said to be priced out of the market. Such a statement is justified only where inefficiency and waste exist.

Dr. Barnett is director, the Harper Hospital, Detroit, Michigan, and president of Michigan Hospital Service.

# Veterans Care Program

GUY F. PALMER

EARLY IN the fall of 1945, a small group of Detroiters met in the headquarters of the Wayne County Medical Society to discuss the pyramiding problems of medical care for veterans of World War II.

Demobilization of the armed services was in full swing, and hundreds and thousands of veterans were being discharged daily to return to civilian life. Many of these veterans still suffered from the effects of battle injuries and disease. Many would require medical care for months and, perhaps, years to come. Under laws passed by Congress it was the government's responsibility to provide this medical care, but the question of how this was to be done remained to be answered.

In the group that met that day in Detroit nearly four years ago were representatives of veterans organizations, Michigan Medical Service, civic leaders, doctors and Veterans Administration officials.

Heading the VA representation was Guy F. Palmer, manager of the Detroit Regional Office, the federal agency charged with the actual administration of medical and other benefits to Michigan's veterans of all wars. Dr. Stanley W. Insley, then president of the Wayne County Medical Society, was spokesman for the professional group.

Discussion soon centered around a startling new plan that had been conceived by the Michigan Medical Service. Under this plan the entire medical profession in Michigan would be organized to participate in the treatment of disabled veterans, with VA paying the bills through the Michigan Medical Service. When representatives of the Michigan Medical Service revealed details of their plan to Palmer, they found a ready and willing sponsor in the person of the local VA chief.

A veteran of World War I, Palmer had been with the VA since 1922 and had faced a somewhat similar problem at that time. He fully realized however, that the medical problems arising out of World War I would be magnified many times over after World War II, and no one knew better than he that the VA was in no position to handle the situation without a lot of help from the entire medical profession.

With Palmer lending his full support, Michigan Medical Service proceeded to iron out details that would make the plan workable. State and county medical societies threw their support behind the movement, and as 1945 drew to a close the Michigan Medical Plan was completed.

But there were to be many trying days ahead, and at times it seemed that the "Plan" might be lost in a maze of chaotic confusion. The original contract, providing a set schedule of fees, was drawn up by the Michigan Medical Service in conjunction with state and county medical societies and was forwarded to VA Central Office in Washington. It was turned down flat. Weeks passed with little encouragement from other states, but the proponents of the Michigan Medical Plan continued their efforts to put it into effect. The contract was revised and again sent to Washington.

This time it was approved by Dr. Paul R. Hawley, new head of the VA Medical Service.

On January 15, 1946, the Detroit VA office authorized the first treatment under the Michigan Medical Plan. One year later, treatments were averaging from 6,000 to 7,000 a month, and to date Michigan physicians of the veterans' own choice have administered about 300,000 treatments under authorization of the Detroit VA.

With the "Plan" now well into its fourth year, Palmer looks upon "hometown treatment" as a permanent part of the VA operation.

"It has succeeded only because of the wholehearted support and co-operation of everyone involved," Palmer said recently. "That includes Michigan's doctors, the Michigan Medical Service, the veteran himself and, of course, our own (VA) Medical Division."

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*Senator Harry P. Cain,* Republican of Washington, said politically controlled medical systems "hamstring both doctors and patients with a frustrating maze of Government regulations and serial number medical methods. Those who suffer are the people who are really sick and who need careful, personal attention at the proper time, not at a time and in a manner prescribed by a Government clerk or a mimeographed regulation. The inevitable, tragic result of such an impersonal system is a progressive decline in the people's health."

# Narcotherapy in Psychosomatic Disorders

By George S. Evseeff, M.D.
Traverse City, Michigan

WITH THE EXPANDING knowledge of the role our psyche plays in the production of somatic symptoms as well as the somatic disorders influencing our psychic states, we are faced with the problem of adequately and appropriately dealing with them. Once it is ascertained that etiological factors in a given case are emotional and lie in the domain of the psyche, we are immediately presented with the problem of selecting a proper psychotherapeutic approach. Psychotherapy can be facilitated by various pharmacological agents which have a specific action on the central nervous system. One of these agents is sodium amytal, which when administered intravenously modifies the psychic state to such an extent that the patient becomes more amenable to our psychotherapeutic endeavors.

In 1930, Bleckwenn[2] introduced the use of sodium amytal into the field of clinical psychiatry. He first used it to produce sedation in disturbed psychotic patients and later observed that it produced lucid states in hitherto inaccessible patients. Later discovery led him to utilize sodium amytal for the prognostic evaluation of psychotic patients as well as for the purpose of differentiating neurosis from psychosis.

Lindemann,[9,10] in 1932, carried out extensive research in studying psychological changes produced by sodium amytal in so-called normal and abnormal individuals. He worked out a technique of using the drug in pre-narcotic doses (3 to 7 grains administered intravenously) to produce the stimulating effect. According to him, the normal individuals as well as psychoneurotics under the influence of sodium amytal reacted by developing a feeling of well-being and serenity and became more confidential and willing to discuss their intimate emotional problems, with a feeling of relief following such catharsis. The psychotic patients reacted by becoming more friendly and some of them emotionally warm. It did not seem to influence the structure of delusional ideas or hallucinations which were part of the patients' clinical pictures. In normal individuals, it did not produce delusions, hallucinations or dreamlike experiences. However, if abnormal thoughts were present but not previously expressed, they were likely to be brought out into the open.

Horsley,[8] in 1936, introduced the term narcoanalysis for the technique of employing a barbiturate intravenously to facilitate psychotherapy. His theory included both biochemical and psychodynamic concepts, in that barbiturates so administered tended to depress higher cortex and diencephalon, with resulting diminution of the conscious state enabling a patient to release anxiety-laden attitudes which otherwise would have been too painful to permit their conscious expression. Horsley used a variety of barbiturate derivatives, such as nembutal, evipal and pentothal.

Wilbur[16] used sodium thioethamyl intravenously, which is an ultra-short-acting drug. He feels that this drug aids in the establishment of a good relationship between the doctor and the patient, and makes the latter more accessible to psychotherapy.

Grinker[4,5] was the first one to use the term narcosynthesis. He believes that abreaction under the influence of sodium amytal is not sufficient in itself, as far as successful treatment of neuroses is concerned. He also stressed the quick establishment of transference towards a therapist, which has to be followed immediately by psychotherapy.

Barbara[1] divided narcoanalysis into two phases: the first stage consists of the development of transference and the analysis, and the second stage consists of interpretation of the material produced and the synthesis. As a result of synthesis, the patient is likely to become more self-assertive, emotionally independent of childhood fixations, and to arrive at some level of normal interpersonal relationships. Resolution of the transference is easier since the patient depends upon the drug for his sense of well-being and relief from emotional tension.

Wagner[14] and others utilized stimulating doses of sodum amytal to aid psychotherapy based on reassurance and suggestion while the patient was under influence of the drug.

Herman[6] succeeded in restoring memory in six cases of hysterical amnesia where other methods failed.

Reitman[12] described a different technique of using sodium amytal, called hypnoanalysis. In a darkened room, the patient was given enough

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sodium amytal to almost put him to sleep. Caffeine was administered hypodermically twenty-five minutes later. Reitman felt that with sodium amytal hypnosis there was an impersonal connection and the patient's personal prejudices were not brought into play, so that course of treatment was not endangered, as may occur in ordinary hypnosis. He felt that evipal was not suitable as it had only narcotic effect without any stimulation.

Hoch[7] used sodium amytal as well as pentothal in the treatment of certain psychosomatic disorders and anxiety states. He administered the drug once a week, and the total number of sessions varied between ten and twenty-five. He made full use of suggestion and psychic catharsis, and his results were gratifying with the patients suffering from peptic ulcers, tachycardia, mucous colitis and head injury neurosis.

New and Kelley[11] came to the conclusion that sodium pentothal was more suitable for acute disorders, and sodium amytal for the usual cases. They also felt that narcosynthesis is more effective if the drug is given in the morning. As a safety measure, they routinely administered atropine sulfate to decrease the possibility of laryngospasm.

Brasier and Finesinger[3] carried out encephalographic studies on the patients who received sodium amytal intravenously. They observed fast frequencies and found that high-voltage fast activity appeared first in the frontal leads, then in the parietal leads and last in the occipital leads, and that it disappeared in the reverse order.

## Method and Material

The present report is based on observations and experiences with 100 patients in the Traverse City State Hospital who received sodium amytal intravenously, according to the technique described below. The particular aspect of sodium amytal administration which is emphasized in this paper is its use as an aid to psychotherapy in psychosomatic disorders.

1. The patient must be comfortably lying in bed.

2. The technique of injection is similar to that used in ordinary intravenous anesthesia, except that the injection is given very slowly. A 10 per cent solution of sodium amytal (sodium isoamylethylbarbiturate) in distilled water is injected in the antecubital region and the rate of injection should not exceed 1 c.c. per minute.

3. During the first few minutes of injection of the drug, the patient is repeatedly told to relax and that he is going to feel pleasantly drowsy without actually falling asleep. Thus, the state of sodium amytal narcosis is augmented by the verbal suggestions which lead to establishment of a hypnotic-like state in the patient. The average patient begins to talk spontaneously after he receives 4 to 6 grains of sodium amytal.

The patient is encouraged to talk freely and as much as he wants to, but if he becomes so drowsy that he is not able to talk, he is given 1.5 to 3.0 c.c. of metrazol intravenously to waken him. Ordinarily, it is not necessary to resort to the use of metrazol, if the sodium amytal is injected slowly enough to avoid this undesirable state of deep narcosis.

## Contraindications and Toxicity

Since the amount of sodium amytal used to produce the narcotic state is very small, there are only a few contraindications for its use, among which the main one is an extensive liver disease. Also, sodium amytal should not be administered to patients with fever and extremely low blood pressure. Smaller amounts should be used in old people and persons with advanced cardiovascular diseases.

Toxicity of the sodium amytal is very negligible. The drug is oxidized by the liver and is completely eliminated in eighteen to twenty-four hours. A few investigators have described occasional cases of idiosyncrasy to the drug, chiefly manifested by skin conditions and neurological disturbances. Horsley states "No case is recorded of a single therapeutic dose, even in an idiosyncratic patient, having a lethal effect."

## Cases

*Case 1.*—A twenty-five-year-old, white, married woman was admitted to the hospital in an acute state of anxiety, with chief complaints of palpitation of the heart, feeling of dizziness and shortness of breath. Physical examination was essentially negative except for tachycardia, dyspnea and generalized trembling of the body. Routine laboratory studies and x-rays of the chest were negative. The electrocardiogram revealed a rate of 110 per minute, with sinus control, and all complexes within normal limits. No pertinent information concerning the psychodynamics of the case was revealed in the initial psychiatric interview. The patient had difficulty in expressing herself because of dyspnea, was extremely preoccupied with her somatic complaints and expressed resentment toward the doctors who could not find any organic condition to account for her distressing symptoms. She was

extremely evasive when questioned about her marital life. Shortly after admission, she was given a series of sodium amytal interviews, according to the technique described above. During the second interview, she revealed the fact that not long ago she had been sexually attacked by her father-in-law and that she had withheld this information from her husband. In the subsequent interviews, much of the important material was obtained pertaining to traumatic experiences in her childhood and early adolescence. She had received no instructions concerning the nature of sex and was totally unprepared at the time of onset of menarche. Her father repeatedly told her that she should beware of the boys because they were always ready to take advantage of an innocent girl. In high school, she was a self-conscious timid girl who avoided boys despite her strong desire to be like other girls. Two years after graduation from high school, she married a man twelve years older than herself. The marriage was a happy one except for the fact that she remained frigid and unresponsive during intercourse, which was performed on rare occasions. Her functional symptoms gradually disappeared during the sodium amytal interviews, and after she developed insight and understanding of the psychosomatic nature of her illness, she rapidly improved and left the hospital symptom-free.

*Case 2.*—A forty-five-year-old, white woman, who had had attacks of asthma for the past twenty years, came in with chief complaints of a feeling of suffocation, insomnia and nervousness. Medications, including adrenalin, gave her only partial relief, and a change of climate did not benefit her at all. She was immensely preoccupied with her somatic complaints, but during the sodium amytal interviews she was able to release a lot of repressed hostility toward her husband, who resented the patient's close emotional attachment to her mother. The onset of her first attack of asthma coincided with an attack of pertussis that her oldest child developed in the first year of life. At that time, she had a difficult time adjusting to married life and felt lost without her mother. Narcoanalysis further revealed that besides dependence on her mother, the patient felt ambivalent toward her. Strong sibling rivalry existed between the patient and her younger brother, who was her mother's favorite. The latest episode of asthma occurred at the time when her mother became seriously ill and the patient was afraid that she might die. As a result of narcotherapy, the patient gained insight into the interrelationship between her asthmatic attacks and her emotional dependence on the mother, following which she reported marked improvement of all her symptoms.

*Case 3.*—A thirty-four-year-old, divorced, white woman came in with the chief complaint of pubic itching. It developed five months after she was married and was particularly noticeable at bedtime. She was treated by several physicians who could not find any organic cause for it. Under the medical care of a woman physician for about a year, she was relatively free of her symptoms, but the improvement was of short duration since the physician moved away from town and no further contact was made. During the initial interviews, she was tense and anxious, feeling extremely sorry for herself. She was quite reluctant to discuss her childhood memories, stating that she could not remember anything significant that might be connected with her present difficulties. She also gave only one reason for divorcing her husband, that being his uncontrolled drinking. She was given sodium amytal intravenously, and during the ensuing ten weekly sessions she spoke spontaneously about her fears and anxieties, and was able to recall some of the traumatic emotional experiences from her earlier life. Although she was divorced from her alcoholic husband, she still loved him. Her father was an alcoholic who abused and mistreated his wife during his drunken bouts. Her mother was a passive, submissive type of woman who was suffering from her own neurotic conflicts. The patient finally was able to express her strong feelings of guilt in connection with masturbation, which she practiced up until the time of her marriage. She had never received any form of sex instruction from her parents and had entered marriage full of fears in relation to sexual intercourse and possible pregnancy. Despite fairly intensive psychotherapy, she was unable to develop sufficient insight to benefit her to any great extent. She obtained only partial relief following narcotherapy and discharged herself from our services.

## Discussion

The precise mode of action of intravenously administered sodium amytal on the central nervous system has not been definitely ascertained. The primary action seems to be on the higher cortical centers, without direct effect on glands, smooth muscles, peripheral vascular and neural systems. The outstanding features of it are alterations in the state of consciousness, increased suggestibility and a state of hypermnesia. The observed changes in patients' attitudes and emotions were quite similar to those encountered in persons who are under the influence of alcohol. Thorner and Herman believe that it is due to suppression of the higher cortical inhibitory centers. According to our observations, patients under the influence of sodium amytal become quite drowsy, but communicative, with a tendency to be less inhibited and more apt to reveal suppressed emotions with a minimum amount of anxiety. In addition, they usually have a mild flight of ideas, hypomania and in some instances euphoria. From the psychotherapeutic view, two states merit special consideration, one of increased suggestibility and another of hypermnesia, which may aid materially by shortening the time required to complete the treatment.

The above-mentioned psychological changes can be advantageously combined with various types of psychotherapy, depending upon the nature and severity of the emotional disorder. By the term psychotherapy, we mean everything that may be

done by the physician in order to favorably influence the feeling and thinking of the patient in a way that will lead to the better adjustment of the latter to his or her environment. In any psychotherapeutic setting, this doctor-patient relationship is the most important single factor. Rapport was a popular term used to describe such a relationship, later superseded by the term transference. Transference is a tendency in human beings to relate the emotional attitudes that have developed in their past to the people in their present environment. When this transference is established, the patient sees the doctor not at all as he is, but more or less in the role of one of those individuals who figured significantly in the patient's childhood. When a fundamentally positive relationship exists between the patient and the therapist, catharsis can take place more readily. If a therapist plays the role of a benevolent and permissive parent, the patient is not afraid to express his hostile feelings and infantile libidinal strivings which are not ordinarly accepted or approved. Under the influence of sodium amytal, intensity of anxiety, associated with those unacceptable drives, is not only lessened but can be controlled and regulated by varying the amount of drug administered. As soon as the patient becomes aware of his unresolved emotional conflicts perpetuating themselves from the early days of childhood, he commences to develop insight or understanding of his true self. This invariably is followed by an improvement in the patient's condition. Re-educative psychotherapy must be continued until it reaches the emotional level of acceptance by the patient of his conflicts rather than the intellectual one.

There are no special criteria for selection of the patients for narcoanalytic treatment. Anxiety hysteria and conversion hysteria frequently are amenable to narcotherapy. A large percentage of psychosomatic disorders are based on the psychodynamic principles involved in the above-mentioned neuroses. Recent reports in the literature describe favorable results with narcoanalysis in the treatment of cardiac and respiratory neuroses, various psychosomatic disturbances of the gastrointestinal tract such as peptic ulcers, mucous and ulcerative colitis. Narcotherapy has provided us with a brief psychotherapeutic tool for dealing with acute anxiety states where a conversion of anxiety into somatic symptoms is the predominant feature. One case of cardiac neurosis, one of mucous colitis and three cases of psychogenic asthma were successfully treated by this method. One schizophrenic patient who suffered from asthma prior to the onset of acute psychosis responded exceptionally well to the combined insulin coma treatments and narcoanalysis.

## Summary

1. A brief review of literature dealing with the intravenous use of barbiturates in the field of clinical psychiatry was presented.

2. One hundred patients were studied from the diagnostic, prognostic and therapeutic standpoint, according to the technique described in this paper. Chief contraindications and the toxicity of sodium amytal administered intravenously were discussed. In our series, no complications were encountered.

3. Three cases were selected as illustrations for the use of sodium amytal narcotherapy in the treatment of psychosomatic problems.

4. The use of intravenous sodium amytal as an aid to brief psychotherapy was discussed. Three cardinal principles of psychotherapy, relationship, catharsis and insight, were defined and their dynamics were described in relation to the narcotherapy. Usefulness of narcotherapy in the management of anxiety states, conversion hysteria and various psychosomatic disorders was mentioned.

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# The Climacteric and Its Management

By Howard H. Cummings, M.D.

Ann Arbor, Michigan

THE FUNCTION OF reproduction in the human female gradually declines in the latter part of the fourth decade and usually is completely lost in the early part of the fifth decade. During this period of time, menstruation occurs at lengthening intervals and in lessening amounts until it ceases entirely. Accompanying the gradual cessation of menstruation, atrophic changes occur in the external and internal generative organs. These atrophic changes, which are easily demonstrable, markedly affect the ovaries, thereby causing a temporary imbalance of the endocrine glands. The ovaries play the leading role during a woman's reproductive life, assisted by the pituitary gland and possibly the thyroid and adrenal glands. While our knowledge of the part that each gland plays is still incomplete, there is scientific proof that the close interrelation of the endocrine glands is disturbed when one gland is impaired in its function. In time nature re-establishes a satisfactory endocrine balance.

This critical period in a woman's life—when the power of reproduction is lost and menstruation gradually ceases, when atrophic changes take place in the generative organs and the endocrine glands are thrown into a state of imbalance—is designated as the climacteric. The term *menopause* is frequently used by both physicians and laymen to designate this period of time and change, but scientifically it is not correct. Literally, menopause describes only one prominent objective sign of the climacteric. By usage, however, the two terms have come to be accepted as synonymous.

The multitudinous symptoms experienced by women during the climacteric are difficult to explain on the basis of an endocrine imbalance alone, but when disturbances of the autonomic and peripheral nervous systems are reviewed in relation to endocrine crises, the explanation of the symptoms of the menopause becomes clearer. As a matter of fact, the most prominent symptoms of this period fall into two groups: first, psychic symptoms; second, disturbances of the autonomic and peripheral nervous systems.

Under the heading of psychic disturbances are: emotional instability, melancholia, weeping, morbid worrying, insomnia, fatigue, self-depreciation, self-accusation, jealousies, suicidal thoughts, lack of concentration, and impaired memory.

Common symptoms attributed to disturbances of the autonomic and peripheral nerves are: hot flashes, chills, attacks of sweating, palpitation, dyspnea, vertigo, headaches, paresthesias, pruritus, and hyperesthesias. These lists are far from complete, but they do enumerate the most frequent symptoms of the menopause.

It would be simple for the physician, when confronted by such an extensive and complicated symptom-complex as the patient relates, to explain all of the disturbances on the basis of menopausal changes. However, during this same period, numerous diseases may appear and in their several courses produce all of the symptoms mentioned. The degenerative and metabolic diseases, such as arteriosclerosis and hypertension, cardiac and kidney diseases, diabetes, obesity and anemias, develop during the forties and fifties. Malignancies and benign tumors of the pelvic organs frequently appear. Menstrual disturbances, especially menorrhagia and metrorrhagia, often occur. Thyroid deficiencies or hyperactive states are seen during the climacteric, and neuroses and psychoses often make their initial appearance or recur at this critical time. These facts make it imperative when women complain of supposedly menopausal symptoms that physicians record complete histories and make thorough examinations.

The medical management of the woman in the climacteric may be very simple, or it may require all of the physician's resourcefulness, skill and judgment. Not all women require medical attention during this period of life. There is a wide variation in the statistics on this important question. Norris estimates that 90 per cent of healthy women go through the climacteric without experiencing any symptoms which interfere with general health or domestic and social activities. A contrary view is expressed by Hawkinson, who estimates that 75 per cent of all women experience distressing symptoms during the climacteric. Estimates similar to Hawkinson's in this country range

from 65 to 85 per cent. But all statistics dealing with the frequency of disturbing climacteric symptoms are only estimates. No accurate figures are available. Nevertheless, physicians who are consulted by women in this age group know that a large proportion of these *patients* have distressing symptoms attributed to the climacteric.

The picture of the menopause is beclouded in the minds of many women by superstitions and old wives' tales. Among the most common misconceptions are that the sexual life of the woman ceases at the menopause, that her usefulness to her husband and family is largely ended, that numerous and fatal diseases will attack her, and that the climacteric and senescence are synonymous.

Many times the only medical attention required by these patients is a reassuring consultation in which misconceptions are cleared away, and in which the physical changes taking place and causing the syndrome are explained. But this consultation should be delayed until the physician has satisfied himself by a careful history, a thorough physical examination, and all of the clinical tests necessary, that disease is not present and causing the symptoms.

Knowledge of psychology and psychiatry is often essential to the successful treatment of patients in the menopause. No group makes more demands upon a physician's time or requires so much reassurance and personal encouragement. In fact, many cases with predominating psychic symptoms need the attention of the psychiatrist. The psychoses appear, and self-destruction may occur when women develop mental depression, groundless suspicions and jealousies, lose interest in their normal activities and accuse themselves of uncommitted and unpardonable sins. Patients who develop involutional melancholia—an exaggeration of the menopausal complex—with suicidal tendencies should be treated in institutions by trained psychiatrists.

Most women in the climacteric suffer from relatively mild symptoms. In order of their frequency, Hawkinson lists the symptoms as follows: nervousness, menstrual disturbances, flushes and chills, excitability, fatigue and lassitude, depression, irritability, insomnia, tachycardia, vertigo, decreased memory and concentration, headaches, frigidity, numbness, tingling, and sweating Fortunately, most of these symptoms may be alleviated or banished entirely by modern hormonal therapy.

Many estrogen preparations are available to the physician today. Most of them are effective. Each practitioner has favorite preparations and methods of administering them. Individual differences in response to drugs make it necessary to try our varying dosages. All of these drugs fall into one of three groups: first, natural estrogens (estrone, estradiol); second, synthetic (diethylstilbestrol, hexestrol, benzestrol); third, chemically modified natural estrogen to increase their effectiveness by slowing down the rate at which they are absorbed. For this purpose natural estrogens are combined with benzoic propinate or palmitic acid. Solid estrogens in pellets and crystalline forms, when injected under the skin or into muscle, will likewise delay absorption.

Time and experience have served the medical profession well in evaluating newer methods of treatment. This is especially true of estrogenic therapy in the climacteric. Medical opinion today concerning the use of the estrogenic drugs in the management of the menopause is not unanimously in favor of them, but some generally accepted ideas and methods are now well established and extensively followed.

The estrogenic hormones obtained from natural sources are known to be well tolerated by women whether given by the oral, subcutaneous, or topical routes. However, they are expensive and when used for months or, as sometimes happens, for several years, they cause an economic burden on the patient. Yet the synthetic estrogens, though just as effective in producing favorable responses, are more irritating and toxic, but because they cost less they are available to all women needing them. Nausea and vomiting, which are the most common ill effects of the synthetic preparations, may be overcome by small doses given with food or upon retiring, or by omitting the drug at intervals, or by sedation accompanying the medication. When the natural or synthetic estrogens are suspended in oily media for hypodermic use and are given by this method, local irritations sometimes occur. Skin sensitizations and general allergic manifestations may also be produced.

In beginning treatment with estrogenic agents, the dosage should be sufficient to alleviate the symptoms or to cause their prompt cessation. Too small doses will make the patient lose confidence in the efficacy of the drug. Large doses, however, should not be continued; rather they should be

reduced as rapidly as possible to a point where the subjective symptoms are held in abeyance. From time to time, for short intervals, the medication may be stopped to test the patient for recurrence of the symptoms. Caution should be used, however, not to stop estrogen treatment suddenly or for too long a period of time. A sudden withdrawal of these drugs will produce uterine bleeding. Overdosage with estrogen may likewise bring about troublesome bleeding. When this occurs in women who have ceased menstruating, the physician is faced with the diagnostic problem of ruling out malignancy of the uterus. Frequently a diagnostic curettage is necessary to answer this question.

No definite plan of estrogen therapy can be given, for each woman reacts in a different way. Most women in the menopause show exacerbation of symptoms in monthly cycles, or at gradually lengthening intervals. Medication may be increased and decreased to meet these cycles. During the early period of treatment it is preferable to have the patient visit her physician for consultation and reassurance. A hypodermic injection of a crystalline preparation may be given at the time of the office visits. In certain cases these treatments may supplement oral administration. The estrogens, whether natural, synthetic or chemically combined, which may be taken by mouth make up the most generally used and most valuable drugs for treatment of the climacteric. Once the proper dosage is established, the oral route is most convenient for both patient and doctor. Patients using these drugs, however, should have constant medical direction throughout the whole time of treatment. Physicians should gradually withdraw these drugs and warn their patients not to resume taking them without medical advice.

Are there any contraindications to the use of the estrogens in the climacteric? Women who have malignancies or have had previous treatment for malignant disease should not be given estrogenic therapy. There is one exception to this almost inflexible rule. Older women with advanced malignancies and metastases in the soft parts of the body obtain palliative relief from their suffering by this treatment, but are not cured. Usually cancerous neoplasms are lighted up and their course accelerated by the administration of estrogen preparations. They should never be prescribed until the absence of malignancy has been determined. There is no definite proof that any of the estrogens cause cancer.

Women who have endometriosis or adenomata of the uterus usually improve in health and often become free from symptoms as the climacteric draws to an end. Excessive bleeding and pain, however, may reappear under estrogen therapy.

Thompson believes that women with fibromata of the uterus should not be given estrogens during the menopause as they may cause profuse hemorrhage. Opposed to this view is Karnaky who advocates the use of large doses of diethylstilbestrol, 25 to 250 mg., injected directly into the anterior wall of the uterus to stop functional bleeding and hemorrhages due to fibroids. He believes that by raising the estrogenic blood level above the estrogenic bleeding level, the hemorrhage is checked.

Certain menopausal patients are overstimulated by estrogenic therapy and all of their symptoms exaggerated by it. These women should be treated by other means. Estrogen preparations may cause addiction. It is not unusual to find patients who seemingly cannot do without these drugs and have taken them for a number of years without professional advice. At times they present themselves to physicians because of profuse bleeding brought on by overdosage or sudden withdrawal of the drug. Usually a diagnostic curettage is necessary to rule out malignant changes in the uterus. Following a gradual withdrawal of the drug, substitute therapy must be instituted. Prolongation of the symptom-complex of the climacteric may be caused by unnecessary and too long-continued estrogenic therapy. Periods of gradual withdrawal of the drug should therefore be prescribed. If the symptoms disappear or are not troublesome, all estrogens should then be stopped.

During the climacteric women who have menstrual disturbances, such as premenstrual spotting, menorrhagias and metrorrhagias, present many difficult problems to the attending physician. Treatment of this group is hazardous unless, by examination, pelvic pathologic conditions are ruled out. Estrogenic therapy often is unsuccessful and radical procedures are necessary. Transfusions of blood, curettage, intra-uterine radium, deep x-ray therapy and hysterectomy are sometimes required to manage profuse bleeding of the menopause. Certain medicines, however, may be tried, often successfully, before using operative means. Extract of thyroid is especially useful. Well-tolerated doses

may be maintained for long periods of time, but while the patient is using this hormone, signs of toxicity must be watched for and basal metabolic rates determined.

Androgens are not foreign to the blood stream of women, and they may be of great value in treating menstrual complications of the climacteric. The medical profession has been frightened by reports in the literature of masculinizing effects of the male sex hormone. It is true that large doses of these useful androgens will cause hair to grow on the face, a lowering of the voice, atrophy of the breasts, and even enlargement of the clitoris. About 400 mg. of testosterone propionate, given in a period of one month, will produce masculinizing effects, but rarely is it necessary to give over 250 mg. of the androgens a month in the treatment of menopausal bleeding. Twenty-five mg. of testosterone, given by the hypodermic method three times a week, will lessen bleeding, and 10 mg. of metandren by mouth two or three times a week is sufficient to reduce the blood loss from adenomata and fibromata complicating the climacteric. The androgens find their greatest use in gynecology when patients have had previous malignancies or functional bleeding treated by x-ray, radium or surgery, and estrogens have been contraindicated. Androgens relieve troublesome menopausal symptoms. Hot flashes frequently are checked by the use of these hormones. All masculinizing signs disappear within a few months after discontinuation of the male sex hormone.

A useful group of drugs for the climacteric are the barbiturates. No other treatment is necessary in some cases, and when they are given with the estrogens, the dosage of the female hormone may be greatly reduced. Doses of ¼ gr. of phenobarbital given one-half hour before meals and 1 gr. at bedtime may give complete relief from symptoms.

Many physicians experience great difficulty in weaning menopausal patients away from the estrogen preparations. Christy, in 1945, recommended vitamin E in menopausal therapy in place of estrogen. Personal experience of over two years duration has confirmed his claims. Women in the menopause are effectively relieved of vasomotor instability. There are no stimulating effects, and it does not cause changes in the genital organs or the breasts. It is well tolerated and has no bad side effects. It may be that the beneficial effects of vitamin E are purely psychological. Perhaps this is just a placebo. However, when ephynal acetate in 10 mg. doses is given three times daily, many menopausal patients are entirely relieved of their disturbing symptoms.

After a period of months or years, women in the menopause gradually realize that their peculiar and troublesome ailments have disappeared. They feel unusually well. Ambition returns, and they take their active places again in the home circle and in society. If free from organic disease, they can look forward to many more years of usefulness and happiness. The gratitude of these women is a source of professional satisfaction to physicians who have patiently and skillfully led them through this trying time.

MSMS

**TEMPEST IN A TEAPOT**

The affair of Private Dolan is explained by four large paper clippings. Supt. Shaw and Dr. Farrand did not agree—the doctor resigned. There was a charge of neglect of Private Dolan. It was charged the patient had been compelled to wait four hours in the hall without medical treatment. Dolan was a private in the Fifth Regiment with a fracture of the shoulder blade. The regiment surgeon sent the patient in thinking that Gen. Pingee had arranged for the use of the hospital. The hospital authorities were charged with asking where the money for his care was coming from. The delay was because Dolan had been sent in from Island Lake with a letter to Dr. Farrand who could not be located for three hours according to this Superintendent, who is reported in the paper to have said, "Dr. Farrand is a nominal member of the staff and beyond the spirit of ill will manifested his resignation isn't of any consequence. I guess the institution can get along without him." *Evening News,* Detroit, May 5, 1898. From an old scrap book at Harper Hospital.

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**FIND ANTIBIOTIC EFFECTIVE AGAINST VIRUS PNEUMONIA**

Virus pneumonia responds favorably to aureomycin, according to Gordon Meiklejohn, M.D., Berkeley, Calif., assistant professor of medicine at the University of California Medical School, San Francisco, and consultant in virology for the California State Department of Health, and Capt. Robert I. Shragg, who made a controlled study of the newer antibiotic drug as a treatment for this virus disease of the lungs.

No previously available drug has been found effective against virus pneumonia.

# Acute Bacterial Endocarditis Complicating Pregnancy

By George N. Ferris, M.D., and
Clarence E. Toshach, M.D., F.A.C.S.
Saginaw, Michigan

THERE IS A notable paucity in the literature of reports concerning acute bacterial endocarditis complicating pregnancy, particularly in recent years. Undoubtedly, the almost routine use of antibiotics with the onset of fever has cut down the chain of events that leads to this dread complication. However, we feel that occasional cases will continue to challenge the skill of the obstetrician and the internist. The following case is being presented in the hope that our efforts may be evaluated and that others may succeed where we failed.

## Case Report

M. L. G., a seventeen-year-old Mexican woman, was delivered of a normal full-term baby on July 29, 1946. Labor was short and uncomplicated. The postpartum course was uneventful. She did not have another menstrual period. The patient visited her physician early in her second pregnancy for diagnosis, but she did not see him again until the onset of labor on November 2, 1947, when she was admitted to Saginaw General Hospital. She complained of fever and malaise and had a temperature of 101.6°. The patient gave no definite history of recent upper respiratory infection, but her husband volunteered that she had a cold for several days prior to hospitalization. She denied any history of rheumatic fever, heart trouble, nephritis, or other serious illnesses. The patient had never been operated upon. The menstrual history was not remarkable.

The physical examination revealed a small, well-developed, fairly well-nourished Mexican woman who appeared toxic and acutely ill. Her skin was clear and warm to touch. No petechiae were seen in the skin or conjunctivae. Small nodes were palpable in the anterior and posterior cervical areas bilaterally. There was moderate edema of both upper eyelids. The tonsils were enlarged but did not appear infected. The lungs were clear. The heart was slightly enlarged to the left. There was regular sinus rhythm, with no murmurs and no thrills. The fetus, apparently near term, was presenting by vertex, and the fetal heart tones were of good quality. All reflexes were within normal limits.

Empirically, the patient was started on penicillin and given sodium sulfadiazine intravenously. Shortly after admission, the patient went into labor spontaneously and was delivered of a normal, slightly toxic, premature infant. After a stormy course, the baby went on to full recovery and is in good health at the present time.

The mother developed a temperature of 104° the day following delivery, November 3. It climbed to 105.2° the following day. At this time the patient complained of aches in the arms, neck, and left hip. There was moderate abdominal distension. A harsh, blowing systolic murmur was heard over the mitral area for the first time. Petechiae were noted in the conjunctiva of the left lower lid.

Chest rays taken at this time were negative except for left ventricular hypertrophy. The Widal test was negative, and the heterophile antibody was not diagnostic. After consultation with the medical department, it was decided that septicemia and bacterial endocarditis were the most likely diagnoses, and blood cultures substantiated this. Three successive cultures on November 4, 5, and 6 proved positive for staphylococcus aureus with hemolytic properties.

On November 6, vaginal bimanual examination disclosed no pelvic abscess or induration. The following day the patient appeared somewhat improved clinically, except that the respirations were short and grunty in character and the temperature remained septic in type. There were a few crepitant râles in both bases. The abdominal distension continued. On November 9 she complained of severe pain in the left flank. There was marked tenderness over this area.

Blood culture on November 13 was again positive for hemolytic staphylococcus. Chest x-rays obtained on November 21 revealed prominent bronchovascular markings bilaterally. X-Rays of the thoraco-lumbar area showed no metastatic abscesses.

Her fever continued to be of the picket-fence variety, fluctuating about a base line of 104°. The patient's condition gradually deteriorated. She lapsed into a semi-comatose state and expired on November 25.

Laboratory work showed a negative Kahn and a positive Rh factor. Urinalyses were obtained regularly, and at all times a trace of albumin was present. There was never any sugar or acetone in the urine, and only a few white blood cells and occasional red blood cells were noted. The blood hemoglobin was not less than 76 and as high as 84 per cent during the illness, and the red blood count ranged from 3,950,000 to 4,520,000. The white blood count varied from 13,650 to 19,750. The polymorphonuclears fluctuated between 88 and 97 and the lymphocytes from 11 to 13 per cent. The nonprotein nitrogen on November 18 was 22.5 mg. per cent.

*Therapy.*—On admission the patient was started on 40,000 units of penicillin every three hours and was given 5 grams of sodium sulfadiazine intravenously. On November 4 the penicillin was increased to 60,000 units every three hours, and sulfadiazine was given in doses of 15 grains every 4 hours. The patient received 500 c.c. of whole blood on November 4 and again the next day. Between November 8 and 24 she was transfused with 250 c.c. of blood on ten occasions. On November 8 the penicillin was increased to 150,000 units every two hours, and sulfadiazine, grains 7½, and sulfamerazine, grains 7½, were administered every four hours. Since the pa-

From the Department of Obstetrics and Gynecology, Saginaw General Hospital.

Fig. 1. Vegetative endocarditis.

Fig. 2. Splenic infarct.

Fig. 3. Kidney infarct.

tient was not responding to penicillin and the sulfonamides, streptomycin, in doses of 0.5 gram every three hours, was started on November 4. On November 24 the the penicillin dosage was increased to 500,000 units every three hours. The patient received a total of 33,360,000 units of penicillin, 42,500,000 units of streptomycin, and 3,500 c.c. of whole blood. During the course of the illness, the fluid balance was maintained with intravenous fluids.

*Postmortem Examination.*—Only the significant findings will be noted. There were numerous petechial hemorrhages in the conjunctivae. There was extensive congestion and edema of the lungs. The heart weighed 200 grams. The valves were not remarkable except for the mitral. On this valve were found two large friable vegetations, each measuring 1.5 cm. in diameter (Fig. 1). These were firmly attached to the valve cusps and separated for a distance of about 5 cm. Sections through the vegetations showed them to be composed of fibrin and clotted blood. There were large masses of bacteria present, along with numerous inflammatory cells. Necrosis was prominent throughout this tissue. No evidence of previous endocardial disease could be found. Myocardial sections showed small areas of focal necrosis with collections of inflammatory cells and degenerating muscle fibers.

The liver weighed 2,200 grams and was markedly congested. The spleen, weighing 708 grams, was covered with adhesions. Visible through the capsule was a large infarcted area which occupied about one half of the splenic surface (Fig. 2). Sections through the infarct showed complete necrosis of the splenic tissue. It was rather sharply demarcated from the adjacent splenic stroma.

The kidneys weighed 200 grams. Numerous petechial hemorrhages were noted on the surface. In the right kidney there were two yellowish infarcted areas in the midportion, each measuring 1.5 cm. in diameter. The left kidney contained one infarct in the lower pole. Microscopic study revealed these infarcted areas as regions of necrosis which were sharply delineated from the adjacent renal parenchyma (Fig. 3).

Petechial hemorrhages were present in the bladder mucosa. In the uterine cavity and extending down into the cervix there was a large piece of dark, friable hemorrhagic material which appeared to be placental in character. This was firmly attached to the boggy uterus. Sections showed this to be a piece of necrotic material which was largely fibrinous and in which shadowy chorionic villi could be identified.

## Discussion

Hoyt states that acute bacterial endocarditis is uncommon, occurring in well under 1 per cent of all types of heart disease. In 1945, Hoyt and Bissel[5] reported a case of staphylococcus endocarditis treated successfully with penicillin in doses of 10,000 units every two hours for fourteen doses, or a total dose of 1,680,000 units. Blood culture was positive up to the eighth day, then permanently negative. Dolphin and Cruickshank[2] reported on six cases of acute bacterial endocarditis treated with penicillin in total dosages of 646,000 units to 2,300,000 units. Three patients lived and three died. Two of these cases were due to staphylococcus aureus. One survived and the other eventually succumbed.

Koletsky[6] feels that acute bacterial endocarditis is not an uncommon occurrence in puerperal

septicemia. He reports that Matthews and Phillips found seven instances of acute endocarditis among fifty-five cases of septic abortion. Hamilton and Thomson[4] reported that in fifty consecutive postpartum examinations of patients who died of puerperal sepsis, fresh endocardial vegetations of number and size to warrant a diagnosis of acute bacterial endocarditis were found in five.

We have been unable to find in the literature any cases of acute bacterial endocarditis complicating pregnancy that were treated with our newer antibiotics. Our case was submitted not only to add to the meager literature on the subject but also because of several interesting points that were brought up.

When did the patient develop her endocarditis? We feel certain she had it the day following delivery, when we first heard the loud systolic murmur. Whether the patient had already developed septicemia and was accumulating vegetations on the mitral valve when admitted, or whether there was a large scale invasion of the blood stream by the staphylococcus immediately after delivery, we cannot say. If the latter is true, we must admit that at least some strains of staphylococcus can attack a previously normal heart in the presence of penicillin.

What was the relation between the retained secundines and the bacteremia? At first we felt that we might be criticized for not curetting the uterus, in spite of the persistently high fever. However, the uterine retention of pieces of placenta and membrane is not uncommon, and few of these cases ever develop puerperal sepsis. We refrained from curettage in the belief that the only effect would be dissemination of the infection.

Would larger doses of penicillin given earlier have altered the outcome? It is lamentable that we were unable to obtain a penicillin sensitivity test on the organism. We administered gradually increasing doses as the patient showed no signs of responding. It is possible that we were only building up the immunity of the staphylococcus to the drug. Miller[7] states that some strains of staphylococcus are comparatively resistant and a few highly resistant to penicillin. This is due to the ability of the resistant strains to produce penicillinase, an enzyme which inhibits the effectiveness of penicillin.

Given this case to treat again, we would certainly employ larger doses of penicillin as soon as the diagnosis was established. We are looking forward to further reports on the battle between penicillin and the virulent staphylococcus that attacks the valves of the heart.

The authors are indebted to Drs. Lohr and Bucklin of the Department of Pathology for their aid in presenting this paper.

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## MSMS

### STRONG LEADERSHIP

Although the community has a right to expect strong leadership from the medical profession in removing the economic shock from the cost of medical care, doctors cannot do this alone.

Doctors are eager to develop voluntary insurance against costs of hospital and medical care and are increasing their co-operative efforts with labor, management, and with community leaders to do so.

Health must be earned—it cannot be received as a gift. Millions of families have to be taught how to live a healthy life in their homes. One-half the chronically ill are in their present condition in large measure because of ignorance, willful neglect, or failure to observe and practice even the most elementary principles of hygienic living.

Their condition is not, as some are led to believe, primarily due to past failures in our medical facilities. Prevention of disease by developing sound health habits on an individual basis in the schools is money well invested for any community.

Only by attachment to a family doctor, whether he practices alone or with a group of his colleagues, will people have the advantages of positive health supervision and the early and comparatively inexpensive detection of serious illness when it can be most successfully treated. —J. R. Miller, Trustee AMA.

### SPELL IT THIAMINE, SAYS VITAMIN AUTHORITY

"Approved spelling" for the chemical name for vitamin $B_1$ is thiamine, not thiamin, says Dr. R. R. Williams of New York, who first synthesized this vitamin. In a note to *Science* (May 20) he says he is asked periodically about the spelling.

"Thiamin" is the spelling he suggested in 1937, shortly after he had synthesized the chemical. Later, however, the U. S. Pharmacopoeia adopted the spelling, "thiamine," adding the final "e" to indicate the chemical characteristics of the compound. Chemical and medical journals have now followed this lead.—*Science News Letter*, June 4, 1949.

# Random Relationships of Experimental Embryology and Genetics to Pathology

By Stanley P. Reimann, M.D.
Philadelphia, Pennsylvania

IF WE TRANSLATE into general terms the basis of the microscopic pathologic diagnosis of tissues, we would call it part of the differentiation and organization problems. We attempt in pathological diagnosis to name a given process, and from this name implications flow both forward and backward. Thus, in the case of tumors we attempt to state not only from which tissues a tumor arises, for this is a gross diagnosis, but also microscopically, from which cells. On the other side, from our opinion as expressed in a name, we give a prognosis, that is, we make a prophecy as to what would have happened had the piece of tissue not been removed, and what in all probability will happen provided the surgeon has not removed the lesion in toto.

Furthermore, in many instances the etiology of a given lesion is implied in the name given, whether that be the tubercle bacillus in a tuberculous anatomic lesion or a granulosa cell tumor of the ovary when a periductal fibroma of the breast appears in a woman past the menopause.

With all the complications, it is a wonder (if this is a scientific term) that pathologists can do as well as they do.

You will notice that the word "name" appears frequently in the above. Without laboring the point it is apparent that names are extremely important in understanding, not only with our clinical confreres but even among ourselves. There has grown up in pathology a language of its own, sometimes difficult to understand even among pathologists and often difficult to reconcile with the terminology of the basic science on which pathology rests, namely, biology.

It would seem that the more our language coincides with that of the basic subject, the more understandable it would be to others as well as ourselves, and the more flexible it would be as new facts and concepts arise in the whole subject of biology. It is interesting to note that at least attempts are being made to clarify the language of pathology in both the fields of hematology and neoplasms.

As stated, it is with the differentiation of cells and the organization of tissues that we deal primarily. By differentiation is usually meant the change from the more general to the more specific. There are all degrees to this "more specific," and in this are crucial points of many a problem.

Biologists generally do not like the terms "potent" or "potencies," but they have no agreed substitute for them. Therefore, we might define them as the possibilities within a cell. In pathology we use the term "totipotent," meaning that all of the tissues and cells of a given organism can be developed from such a cell. Such a one is the fertilized ovum, or, by parthenogenesis, an unfertilized ovum. Differentiation begins quite early in certain species—even in the fertilized ovum—and in other species begins later, perhaps not until the sixteen-cell stage has been reached. The terms for these two contrasting ova are mosaic and regulatory. Of course, differentiation has already occurred in all ova and spermatozoa before union, for their maturation may be considered a type of differentiation.

If differentiation toward the formation of a new organism begins immediately in the fertilized ovum, removal of parts leads to defects in the completed organism. If, on the other hand, the ovum is regulatory, and differentiation has not proceeded, removal of parts is "regulated" (perhaps a better word is compensated) and no defects appear. Not only in the ovum does this occur, but regulation or compensation extends much further along in the development of regulatory organisms than of mosaic, even far along. Among other evidence, probably the best known example for the classification of the human fertilized ovum as regulatory is afforded by the Dionne quintuplets. Congenital defects are relatively rare in the human species, perhaps for this reason, and many defects are hereditary, an entirely different mechanism.

I choose these well-known phenomena to point out that the potency of many ova is greater than the development of one individual, for as many as sixteen competent sea urchins have been obtained from one ovum by the separation of the blastomeres as they appear. A problem in biology is therefore to determine the potencies of cells at all stages of development and in all tissues. This corresponds to the pathologist's conception of the

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From the Lankenau Hospital Research Institute and the Institute for Cancer Research.

origin of cells from mother cells, usually called "blasts."

How many types of different cells can arise from a given cell which has retained some of its undifferentiated state? How far can a cell and/or its descendants differentiate? What cells have used up all of their potencies, so that no further differentiation is possible? What hinders cells which still retain potencies from expressing them? I need not point out that in these questions lie some of the fundamentals of evolution—further possibilities of development, of ourselves as well as other organisms, for better or for worse.

The ability of cells to differentiate into different qualitative patterns is far greater than was thought possible some years ago. Prospective forelegs can be made to differentiate into hindlegs, and vice versa; prospective epithelium has been observed turning into bone, and vice versa. The conclusion is that the three germ layers can no longer be considered sacred. Furthermore, the theory of embryonal rests as an explanation of, say, a squamous cell carcinoma of the gall bladder has been cut off by William of Occam's razor, i.e., it is an unnecessary hypothesis.

Part of the differentiation problem concerns the processes known as determination, and these are of the utmost importance in the theory and practice of tumors. The potencies of cells become more and more limited as they are expressed. The point at which a given potency in a cell is singled out as the one to be expressed is called the point of determination. Unfortunately, the exact time in the life of a cell at which this takes place cannot be determined by any known method except the one of allowing the cell to proceed onward and show what it was determined it should do. This can be done either in the living organism in which it is present or by transplant into other organisms. As a specific example, a group of cells arising from the head end of a crustacean may turn into either an eye or an antenna, but at one stage of development they can no longer do either, but must do one or the other.

We hear the terms "carcinoma in situ" "precancerous" and like names frequently enough in pathological literature and reports. These terms signify that determination has taken place within a cell or a group, and it has been decided that the descendants of the cell or the group will be cancerous and not normal cells. If biologists assure us that they cannot tell whether determination has taken place within a cell or not, unless they watch it and see what it does, it is quite obvious that the above terms have no meaning in any particular case, but are merely the results of a statistical approximation to the effect that experience has shown such and such lesions in some persons become cancer. Actually, pathologists cannot know whether the determination to cancer has occurred or not, unless an actual invasive cancer is present.

I hasten to state, however, in this connection that practical considerations should lead to the removal of lesions known to have a predilection to becoming cancerous, but they should not be called cancer, for this but confuses our background knowledge and leads to false statistics. The final remark about determination—of many more which could be made—is that when a particular potency of a cell is determined it need not express that potency immediately, but it may remain latent, so to speak, for minutes, hours, days, weeks and perhaps even months, during which its appearance remains that of an undetermined undifferentiated cell. This phenomenon is of great importance in cases such as this: A woman with carcinoma of the breast has had a radical amputation; ten or fifteen years later nodules appear under the skin in the vicinity of the original growth, parts of which the surgeon did not remove. Obviously their potency was determined years before, that is, they were cancer cells, but the expression of their potency in the form of multiplication, partial differentiation into whatever kind of cancer it was, has been held in check. This, a silver lining in one of the dark clouds of malignancy, is capable of investigation and imitation. What are the factors controlling this latent period, and can we imitate them?

One of the special forms of differentiation is called "chemical differentiation." By this is meant that cells develop within themselves tiny chemical laboratories which produce specific products. Thus, thyroxin results from the chemical differentiation of thyroid cells; female sex hormones from the chemical differentiation of ovarian cells. In cases in which the products are quite specific and in which they exert easily recognized influences at a distance, the presence of tumors in which the cells have undergone chemical differentiation sometimes can be diagnosed over the telephone.

Certainly the anatomic appearance of cells lining the stomach and the appearance of many of the carcinomas arising from them are different

from those of the rectum; ergo, where there is an anatomic difference there must also be a chemical and/or physical difference—a point for investigation, especially for diagnostic purposes.

All biologists, including ourselves, are interested in the parts played by the cytoplasm and the nucleus in differentiation. Experiments by Mrs. Harvey and others have shown that cells from which the nuclei have been removed can undergo at least microscopic differentiation. By refinement and elaboration of technique, Briggs has produced nucleusless cells from frog's eggs, and the effect of various substances on their differentiation is beginning to emerge. Especially important is the influence of the organizer, without which a developing embryo fails in morphogenesis.

You will remember the experiment in which Briggs removed parts of tadpoles' tails and, after regeneration had started, implanted bits of frog carcinoma into the fast growing tissues. In spite of the activity of the differentiating and organizing fields to which the normal cells of the regenerating tail responded, the transplanted carcinoma cells failed to respond. Even though the transplanted carcinoma cells contained both cytoplasm and nucleus, and so were not strictly comparable to the nucleusless normal cells with which Briggs later worked, nevertheless, these experiments and many others answer the question asked more than 100 years ago, of whether the trouble in the origin of cancer is outside or inside the cells. Even though the cancer cells were in the midst of highly potent developmental fields, they did not (could not?) respond. Is the defect in the nucleus or the cytoplasm, or both?

In the diagnosis of carcinoma cells, as in the more recently developed and highly useful (if properly done) smear technique, diagnostic differences are both in the nucleus and the cytoplasm. Time does not permit discussion of the various findings in malignant cells and views expressed over many years, such as increased relative size of nuclei and nucleoli, polychromatism and others, but these obviously are parts of the differentiation problem. It will be quite useful to add to what we know, facts about the relative parts played by cytoplasm and nuclei in normal differentiation and just what the disturbances are when they change in malignancy.

Just as there are degrees to the expression of differentiation in normal cells so there are degrees to the perverted differentiation of cancer cells. The quantitative expressions of differentiation of normal cells are conditioned not only by what they attempt to do within themselves but by surrounding conditions which determine first of all their qualitative choice. These include physical forces such as compression and arrangement of the surrounding tissues, and the nutritional milieu. Thus it is with cancer cells also. The change within them is qualitative and may have been initiated by an external carcinogen or even perhaps from internal instability without external help, but the quantitative degree is surely favored or hindered by external conditions. A cancer of the breast, for instance, is composed of small, tightly packed cells; but when these invade the loose axillary tissues, they are able to exert more of their potencies, and thus give the appearance of glandular carcinoma. We might speculate further by guessing that the change to malignancy can vary qualitatively in the various descendants of the original cancerous cell or cells. I am merely trying here to rationalize the well-known fact that blocks taken from different parts of one and the same tumor and its metastases ofttimes differ widely in their detailed miscroscopy. It is needless to rehearse the fact that different metastases grow at different rates, also partly due to the differentiation patterns.

Finally, since the essentials of malignancy, namely, defective differentiation, failure of tissue and organ morphogenesis and invasion, appear from whatever original cause, viruses, chemical or physical agents such as x-rays or ultra-violet light, the change within the cells leads to similar anatomic and physiological behavior.

Obviously an important problem is to determine whether the actual changes, and of course they eventually must be expressed in chemical and physical terms, are the same, and what are the comparisons with normal cells. There are no obvious chemical relationships between the various carcinogens, although Haddow sees energy analogies.

We have stated that the potencies of cells, provided they have any, are greater than their normal developmental fates. Innumerable examples illustrate this point, and a recent one from the field of pathology may be rehearsed. Furth removed ovaries from their normal positions and transplanted them into the spleens of the same individual mice. All of the blood from the spleen goes first to the liver, and estrogens produced by the

ovarian transplant within the spleen are inactivated. This disturbs the balance between the ovaries and the pituitary. Pituitary gonadotropin is produced constantly and in much larger amounts, so the ovarian cells in the spleen are under continual stimulus. After a bit, granulosa cell tumors and/or luteomas appear. Ordinarily the lutein cells are highly differentiated but are transitory and disappear when their function ceases. Under the above experimental conditions they are no longer transitory, are continually stimulated, more cells are produced, and they finally become malignant, and can be transplanted. The lutein cells have been rescued from their normal fate of destruction by becoming malignant—if one cares for that method of expression. Parenthetically, in this case, cancer research has contributed to endocrinology instead of vice versa, as is usually the case.

From this example many implications flow. When added to other evidence, we state, as generalities, that any cell that can divide can become malignant. Stimulation is necessary for the persistence of differentiation within certain types of cells. Thus the cells of adenocarcinoma of the prostate need continuous stimulation to remain differentiated and produce acid phosphatase. If stimulation is removed, as by orchidectomy, or is overwhelmed, as with female sex hormones, their differentiation ceases, they undergo atrophy, and disappear.

Another generalization is that cells can do more than their normal developmental fates. An old and easy generalization is that differentiation and division are incompatible. In this are two loopholes. One is that we cannot tell from ordinary tissue sections how far cells which have divided or are dividing have previously been differentiated; and second, we cannot know from mere inspection, however fine, how far differentiation has removed potency, what determinations have taken place—in short, whether the cell has used up all of its possibilities. We therefore must fall back upon indirect and statistical evidence which indicates that when differentiation has proceeded beyond a certain point, division is no longer possible. This leads to the conclusion that all cell multiplication must come from incompletely differentiated cells. If incomplete they contain at least two and possibly more potencies. The old question of under what circumstances an individual cell can dedifferentiate has also not been answered. That tissues composed of many cells dedifferentiate there can be no doubt, but the problem must be solved by individual cells, the potencies of which are known quantitatively, and there are no known methods of recording these data.

It is recognized that all of these thoughts expressed are quite random and disconnected. It should be possible though to gather a few together, and it seems easiest to do in the form of a definition. Many have tried their ingenuity in defining what a tumor is; some, discouraged in their attempt, have said the only adequate definition of a tumor is that contained between the front and back covers of a treatise on neoplasms. Here is another attempt; and while recognizing that a treatise is really needed for all of the facts, nevertheless, some of the above can be said in this wise.

A malignancy is a mass of cells which arise from and continue to proliferate within an organism, as a result of and in direct proportion to their degree of internal qualitative differences from other cells of the organism, with respect to the potencies of differentiation and organization particularly.

No mere mention of the problems in experimental embryology—and this is all that this paper has done—can be complete without at least mentioning a few problems in a sister subject, genetics. The experimental embryologist tries to discover how the fertilized egg develops. The problem of the geneticist is to describe the constitution of the fertilized egg in terms of units of heredity. The breeding experiments tell about the transmission of these units of heredity; how they act and what they are, are the newer problems. Naturally, there is much overlapping with embryology, cell physiology and biochemistry. In the latter, they deal largely with nucleoproteins, and progress is beginning at least in an understanding of these substances, as complicated as any chemical compounds known.

The old question of which is more important, heredity or environment, is no longer asked in that form, for as such it has no meaning. The proper method of asking so that an objective answer can be found is, what influence does environment have on any given characteristic, and what modification does the one impose upon the other in producing the change under question? Ramifications may be extraordinarily complicated and diffuse, as the example of the frizzled fowl will show. This chicken, called frizzled because its feathers stick out at various angles, is produced by a particular gene area in a particular chromo-

some. The animal, in addition to its frizzling, has only about half as many feathers; as a consequence it loses heat more rapidly. To compensate it eats more! its gizzard, stomach, liver and other digestive apparatus are larger than in a corresponding normal fowl, weight for weight; to maintain its heat, its blood flows faster, there are more capillaries, its heart becomes hypertrophied; it needs more oxidation, its thyroid is enlarged, and it has pop eyes. Thus all the symptoms of exophthalmic goiter are caused, indirectly through a particular genetic constitution in a particular chromosome.

The frizzled fowl may serve as an example to introduce another point not ordinarily considered except by professional geneticists. All the abnormalities in the animal come from a change in the chromosome manifesting itself in the different tissues, but are all the different tissues the same genetically? What happens when cells change their genetic composition and mutate? These are problems not answered, but which come to the fore in discussions of inherited susceptibility to cancer and of the nature of the malignant processes.

That there is an inherited predisposition to the development of cancer, but more in particular for particular places, is attested by the cases of cancer of the breast occurring in identical twin sisters in the same area of the same breast within a few months of each other. Madge Macklin has many interesting examples of cancer in families—in fact, so many that random distribution is a million to one shot. Hereditary immunities in blood group, thalassemia, xeroderma pigmentosum, Recklinghausen's disease, color blindness follow standard hereditary patterns. The peculiar difficulties attending the study of heredity as the basis of various human characteristics are well known but not always applied. Chromosomes and genes do not disappear, except by death without offspring, any more than the chemical elements in chemical reactions disappear. They are shuffled around but remain. Very few people know what killed their grandfathers and grandmothers, let alone ancestors before them. Nevertheless, progress is being made, and departments of human genetics are increasing in number, and data are increasing in amount. Pathology has a task in careful recording, so that help may be given from its peculiar material to professional geneticists.

# New Drugs for Allergic Diseases

By George L. Waldbott, M.D., and
J. J. Gadbaw, M.D.
Detroit, Michigan

IN REVIEWING the vast literature on antihistaminic drugs some important facts stand out: The drugs specifically counteract most of the physiologic effects of histamine. They do not chemically neutralize it nor do they prevent its production in the system; they appear to compete with histamine in its affinity for the cells.

Experimentally, they diminish capillary permeability resulting from histamine; thus they counteract the histamine wheal. They control bronchospasm induced by inhalation of histamine. They prevent shock and death from lethal doses of histamine as well as anaphylactic shock. They prevent contraction of intestinal and uterine strips of guinea pigs, induced by histamine, when the drug is added to the fluid in which the strip is suspended and when it is administered to the intact animal before the experiment. Some of the drugs raise blood pressure which has been lowered by histamine. They do not affect the histamine secretion of the stomach.

Clinically, the antihistaminic drugs inhibit secretion of the lacrimal and salivary glands and of the mucous glands of the bronchial tree due to histamine. They thus counteract excessive mucous secretion, which is a cardinal feature in allergic rhinitis and in asthmatic attacks. They are effective in counteracting asthmatic bronchospasm when administered as an aerosol, by injection, and orally. Because of their inhibitory effect on the allergic wheal, they are useful in urticaria and angioneurotic edema. They produce local anesthesia when injected. When applied topically, they are of value in the treatment of allergic conjunctivitis and in pruritus of eczema and dermatitis.

We should like to present here a clinical evaluation of the following drugs: antistine, neo-antergan, decapryn, "antihistaminique RP-3277," trimeton. For comparative purposes, we shall include the data available from previous observations on

From the Allergy Clinics of Grace and Harper Hospitals, Detroit. Dr. Gadbaw is now located at 23603 Farmington Road, Farmington, Michigan.

TABLE I. RESULTS IN BRONCHIAL ASTHMA

| Drug | Dose | Relief | | |
|---|---|---|---|---|
| | | None | Slight | Much |
| Amphaphrene Aerosol | ½% | 10 (71%) | 3 (22%) | 1 (7%) |
| Amphaphrene Sublingual | 10 mg. | 7 (20%) | 14 (40%) | 14 (40%) |
| Isuprel Aerosol | 1:200 | 2 (20%) | — | 8 (80%) |
| Isuprel Sublingual | 10 mg. | 5 (38%) | 6 (46%) | 2 (16%) |
| Antistine | 50 mg. | 43 (81%) | 7 (13%) | 3 (6%) |
| Benadryl | 50 mg. | 40 (54%) | 14 (19%) | 24 (27%) |
| Decapryn | 25 mg. | 3 (50%) | 2 (37%) | 1 (13%) |
| Neo-antergan | 50 mg. | 45 (52%) | 12 (14%) | 30 (34%) |
| Neohetramine | 50 mg. | 41 (58%) | 17 (24%) | 13 (18%) |
| Pyribenzamine | 50 mg. | 35 (32%) | 25 (23%) | 50 (45%) |
| RP-3277 | 25 mg. | 9 (45%) | 6 (30%) | 5 (25%) |
| Trimeton | 25 mg. | 9 (48%) | 3 (16%) | 7 (36%) |
| Hydryllin | * | 20 (11%) | 46 (26%) | 92 (63%) |

* 100 mg. aminophylline and 25 mg. diphenhydramine (Council-adopted name for B-dimethylaminoethyl benzohydryl ether).

TABLE II. RESULTS IN HAY FEVER AND ALLERGIC RHINITIS

| Drug | Dose mg. | Relief | | |
|---|---|---|---|---|
| | | None | Slight | Much |
| Antistine | 50 | 19 (24%) | 22 (28%) | 31 (48%) |
| Benadryl | 50 | 14 (26%) | 14 (26%) | 26 (48%) |
| Decapryn | 25 | 2 (18%) | 2 (18%) | 7 (64%) |
| Neo-antergan | 50 | 50 (42%) | 36 (30%) | 34 (28%) |
| Neohetramine | 50 | 50 (30%) | 44 (32%) | 59 (38%) |
| Pyribenzamine | 50 | 16 (13%) | 18 (15%) | 86 (72%) |
| RP-3277 | 25 | 4 (14%) | 7 (24%) | 18 (62%) |
| Trimeton | 25 | 11 (11%) | 26 (27%) | 61 (62%) |

TABLE III. RESULTS IN URTICARIA AND ANGIONEUROTIC EDEMA

| Drug | Dose mg. | Relief | | |
|---|---|---|---|---|
| | | None | Slight | Much |
| Antistine | 50 | 4 (16%) | 3 (11%) | 20 (73%) |
| Benadryl | 50 | 4 (20%) | — | 16 (80%) |
| Neo-antergan | 50 | 11 (29%) | 6 (18%) | 20 (53%) |
| Neohetramine | 50 | 3 (14%) | 6 (28%) | 12 (58%) |
| Pyribenzamine | 50 | 5 (11%) | 5 (11%) | 34 (78%) |
| RP-3277 | 25 | 1 (6%) | 3 (19%) | 11 (75%) |
| Trimeton | 25 | 1 (10%) | 6 (40%) | 7 (50%) |

benadryl, pyribenzamine and neohetramine.[2,3] Chemically antistine, neo-antergan, neohetramine and trimeton are similar in structure to pyribenzamine. Antihistaminique RP-3277* is a thiodiphenylamine derivative (reported by Halpern[1] as the most efficacious one in this group). We also wish to report on two additional compounds which are potent bronchodilators, namely isuprel* and amphaphrene. The latter is the sulfate salt of the isopropyl analogue of epinephrine. They have no antihistaminic effect. They are reported to be useful in asthma. Another preparation included here is hydryllin, a combination of aminophylline (0.1 gm.) and benadryl (.025 gm.).†

## Method

Our cases are divided into: (1) hay fever and allergic rhinitis, (2) urticaria and angioneurotic edema, (3) bronchial asthma.** We refrained from listing seasonal and nonseasonal cases individually because such a differentiation has no bearing on the results. The presence or absence of infection was most important in this respect. We, therefore, endeavored to eliminate all cases with detectable infectious changes in the nose, sinuses or lungs.

The medications were administered only when symptoms were in evidence. In most instances, only three to five doses of each were dispensed. Some of the patients were observed personally by us for six to eight hours after the drug was given. Those taking the drugs as ambulatory patients usually reported to us on the following day.

## Results

Table I shows the results obtained with these drugs in bronchial asthma; Table II, in hay fever and allergic rhinitis; Table III, in urticaria and angioneurotic edema.

It may be noted that the antihistaminic drugs closely resembled each other in degree and duration of relief. Their beneficial effect persisted from four to six hours, varying according to the severity of the individual's condition rather than to the drug employed. An exception was noted with RP-3277, the action of which appeared to be decidedly more protracted. In asthma, most relief was obtained from hydryllin, which represents a combination of the bronchodilator aminophylline with benadryl, an antihistaminic noted particularly for its soporific action. Isuprel and amphaphrene follow next in order, if administered by aerosol inhalation. When given sublingually, the relief from bronchospasm was distinctly noticeable within a few minutes. Unfortunately, however, their clinical usefulness was greatly offset by very conspicuous side effects such as palpita-

*Released now as Phenergan (Merck).

*The formula of isuprel is 1-(3′, 4′-Dihydroxyphenyl)-2-isopropylamino ethanol.

†We are indebted to the following companies for the supply of the drugs: Ciba Pharmaceutical Co., Summit, N. J. (antistine and pyribenzamine); Merck & Co., Rahway, N. J. (neo-antergan); Schering Corp., Bloomfield, N. J. (trimeton); Wm. S. Merrell Co., Cincinnati, Ohio (decapyrn); Nepera Chemical Co., Yonkers, N. Y. (neohetramine); Parke Davis Co., Detroit, Michigan (benadryl); Winthrop Stearns Corp., New York, N. Y. (isuprel); Amphac Pacific Laboratories, Everett, Wash. (amphaphrene); Dr. Bernard Halpern, Paris, France (antihistaminique RP-3277); G. D. Searle Co., Chicago, Ill. (hydryllin).

**The classification of extrinsic and intrinsic cases is not adopted in our tables because such a distinction is highly conjectural.

TABLE IV. SIDE EFFECTS

| Drug | Total Cases | Side Effects |
|---|---|---|
| Amphaphrene Aerosol | 14 | 3 (21%) |
| Amphaphrene Sublingual | 35 | 9 (25%) |
| Antistine | 159 | 33 (21%) |
| Benadryl | 152 | 85 (56%) |
| Decapryn | 17 | 7 (42%) |
| Hydryllin | 178 | 62 (35%) |
| Isuprel Aerosol | 21 | 8 (38%) |
| Isuprel Sublingual | 13 | 8 (61%) |
| Neo-antergan | 244 | 61 (31%) |
| Neohetramine | 245 | 38 (15%) |
| Pyribenzamine | 274 | 104 (38%) |
| RP-3277 | 64 | 26 (41%) |
| Trimeton | 131 | 55 (42%) |

tion, tremor, marked nervousness and apprehension. In allergic nasal disease and in urticaria the results of the above antihistaminic drugs compare with those of benadryl and pyribenzamine.

Our experience with eczema, dermatitis, migraine and gastrointestinal diseases is not recorded here because of the relatively small number of cases. In eczema and contact dermatitis they were of use in the relief of pruritus, especially at bedtime. The benefits obtained from topical applications in the form of ointments are doubtful. Application of the ointment on moist lesions aggravated the condition. In true allergic migraine the drugs afforded a great deal of relief.

All the drugs studied produced side effects (Table IV) similar to those already reported. Drowsiness and dizziness were noted most frequently, particularly with RP-3277. Its therapeutic effect, however, outlasted the soporific one by several hours. It can, therefore, be employed to advantage at bedtime. Diarrhea was most common after the use of antistine. Other side effects noted were nausea, muscular twitching, restlessness, dry throat, paresthesia, headache. With several drugs a temporary aggravation of the allergic symptoms (asthma and allergic nasal symptoms) was noted.

In two patients with urticaria who had been taking antihistaminic drugs routinely for some time, the hives cleared up as soon as the drug was discontinued. Sometimes a patient would exhibit side effects from a certain drug on one day, none on another. In some individuals, unpleasant manifestations were noted only from certain drugs while the others were tolerated. Other patients experienced ill effects from every drug which was tried. Rather severe attacks of asthma were encountered following sublingual administration of isuprel, which made us restrict its use to inhalation. Serial blood counts and urine examinations were done on patients who took neohetramine, neo-antergan and trimeton routinely every four hours for more than two months. No unusual changes were detected.

## Discussion

In moderately severe cases of urticaria and angioneurotic edema, the antihistaminic drugs constitute the best remedy available. They are preferable to ephedrine and ephedrine-like products because side effects from ephedrine are more unpleasant. If immediate action is desirable they can be administered intravenously. Here, the soporific effect should be taken into account and the patient should be made to rest for several hours. In very acute and severe urticaria, epinephrine still remains our remedy of choice.

In allergic nasal disease, they constitute a desirable palliative remedy which frequently prevents the development of secondary infection resulting from prolonged mucous secretion. However, the patients should be cautioned of their side effect, and, if possible, avoid them during the day. We found them beneficial used topically as a nasal spray.

In asthma they cannot be considered a substitute for epinephrine and aminophylline. They may be used in conjunction with these medications. On several occasions, we have seen asthmatic attacks subside after intravenous administration of pyribenzamine and benadryl when epinephrine and aminophylline were less effective. Asthmatic attacks of moderate severity respond well to administration of hydryllin.

For the purpose of counteracting the unpleasant effects of the antihistaminics, various medications have been given simultaneously, such as benzedrine, ferrous chloride (20-30 grains daily) and caffein sodium benzoate. Our attempts at evaluating this question have been inconclusive.

Through uncritical newspaper publicity, the public has been misled to consider these drugs as "new cures for allergy." Physicians should be warned against prescribing them indiscriminately and neglecting other more effective measures for control of the disease. Even in urticaria, where they are at their best, they are no substitute for thorough search for causative agents. "Cures" with these drugs have only been reported in such self-limited conditions as serum sickness or acute urticaria.

*(Continued on Page 734)*

# Familial Repetition of Myelomeningocele

By Irvin A. Wilner, M.D.

Detroit, Michigan

WE ARE REPORTING the occurrence of an infant with a myelomeningocele born to a mother who had the same defect at birth. While reports of this malformation occurring in siblings are found in the literature, we have noted none revealing this close repetition.

## Case Report

B. M. was born May 9, 1926, the first child of her parents. At birth, a myelomeningocele about the size of a ten-cent piece, involving the lumbosacral area, was present. She developed a feeding problem and was brought to the Children's Hospital in Detroit from her birthplace in Indiana, October 14, 1926. She was hospitalized until October 25, 1926, no paralysis or muscle weakness being noted. Repair at that time was not advised.

Her feeding problem was controlled, and according to her paternal grandmother, who was our informant, her growth was perfectly normal thereafter. She walked at eleven months, appeared normally bright, and began to speak at about one year.

Her mother subsequently had a second child, who had no congenital malformation. Upon the death of the father, the mother remarried and had three children, none of whom were malformed.

The patient's paternal grandmother admits no history of developmental defects in the family of any variety. None of the patient's siblings have as yet married.

On April 10, 1934, when the patient was eight years old, she was readmitted to the Children's Hospital, and the defect of the back was repaired. She was discharged on May 9, 1934, with the wound healed and in good condition.

At the time of our first examination of the patient in September, 1946, it was noted that she was six weeks pregnant. Physical examination revealed a well-healed scar, six inches long in the area of L-4 to S-1. The patient was otherwise normal. There was no history of congenital malformation in her husband, his siblings, or more distant relatives. She was delivered of a perfectly normal male infant on April 29, 1947.

She was seen again in February, 1948, at which time it was found she was twelve weeks pregnant. She was delivered of a female infant by breech extraction on July 13, 1948. The baby had a myelomeningocele, 2 inches in diameter, involving the lumbar and sacral segments. The infant was in poor condition at birth. Neurosurgical consultants noted paralysis of the lower extremities and questionable early hydrocephalus, and advised against operation. The infant died on the third day of its life, at Mt. Carmel Mercy Hospital, Detroit, Michigan.

## Comment

In obstetrical practice, the question of the repetition of developmental malformations is not infrequently raised by patients in whose families such defects are known to have occurred. The apprehension with which these parents view the prospect of subsequent offspring necessitates an evaluation of the frequency with which certain defects occur.

Despite the difficulties inherent in any study of inherited characteristics because of the complexity of the human genetic background, there are many malformations which appear to be inherited.[6] The regularity with which certain defects occur make them appear to be Mendelian dominant charcters. Such notably are the long bone defects of achondroplasia and agenesia of the extremities. Others appear to be Mendelian recessives, being carried in the germ plasm until mating occurs with an individual carrying the same latent defect. Certain malformations are unexplainable on the basis of Mendelian characters and may be the result of mutations, while others result from disturbances of the intra-uterine environment, as in the intra-uterine amputations rarely seen. Crew[2] lists the derangements which have been recorded as being inherited.

In evaluating the probabilities of recurrence in the offspring of families with one defective infant, Murphy[5] noted that while one malformed child was born per 213 births in the general run of the population in Philadelphia during the period of his study, one infant in eight subsequent births was malformed in families already possessing an abnormal infant. He further observed that the defect found in the first malformed child reappeared in a subsequent sibling in 46 per cent of instances. From his study he concluded that malformations have a strong tendency to duplicate among siblings, and among more distant relatives.[5] He found that defects involving the nervous system constituted 60.5 per cent of the total reported, hydrocephalus being the most common diagnosis.

Spina bifida cystica appears to occur in siblings with great infrequency. Shulman,[9] in his report of its occurrence in two successive children of the same family, cites Butler-Smythe,[1] Wright,[10] and Pendelton.[7] Ingraham and Swan[4] found that 6 per cent of their 277 cases of spina bifida admitted

*(Continued on Page 729)*

# Antipertussis Rabbit Serum in 95 Cases and 15 Contacts

## *Preliminary Report*

By Anthony R. Ceresko, M.D., and
Herbert A. Raskin, M.S.P.H.
Detroit, Michigan

IN DETROIT, Michigan, in 1947 a clinical study was undertaken to evaluate the potential therapeutic value of antipertussis rabbit serum in cases of whooping cough and contacts to these cases. The following report is a review of ninety-five cases and fifteen contacts treated with this serum.*

The clinical impression of the physician in the field was made by the end of the first week following the initial dose. Without exception, the nurse's report of clinical progress and recovery at the end of twenty-eight days following the onset of illness agreed with the medical report. The results were based entirely on clinical impression, since no control cases were followed concurrently. Cases were evaluated in terms of lightening of the severity of spasm, decreased frequency of cough, decrease in amount of vomiting and in improvement in sleeping at night.

Tables I and II present these results.

Of the ninety-five cases treated (Table II), seventy-three cases (76.8 per cent) were classified as "success" and twenty-two cases (23.2 per cent) were determined to be "failures."† Among those

TABLE I. AGE DISTRIBUTION OF STUDY GROUP

| Study Group | Total | Under Six Months | Six Months to One Year | One Year | Two Years | Three Years | Four Years | Five Years |
|---|---|---|---|---|---|---|---|---|
| Cases | 95 | 16 | 10 | 19 | 19 | 16 | 8 | 7 |
| Contacts | 15 | 12 | 3 | 0 | 0 | 0 | 0 | 0 |

TABLE II. EVALUATION OF CLINICAL RECOVERY OF 95 CASES OF WHOOPING COUGH FOLLOWING ADMINISTRATION OF ANTIPERTUSSIS RABBIT SERUM

| Case* | Total Cases | Success | | | Failure | | | |
|---|---|---|---|---|---|---|---|---|
| | | Total | 50% or More Recovery | Definite Improvement: Complicated | Total | No Improvement: Complicated | No Improvement: Short Duration | Definite Failure |
| Total Treated | 95 | 73 | 65 | 8 | 22 | 3 | 8 | 11 |
| Treated Within First Week | 27 | 20 | 18 | 2 | 7 | 1 | 2 | 4 |
| Treated After First Week | 68 | 53 | 47 | 6 | 15 | 2 | 6 | 7 |

*Treatment within first week of development of whooping or vomiting.

The diagnosis of these cases of whooping cough was based on clinical history and findings, including the white blood cell count and the differential count. The serum was given within the first week of the development of whooping or vomiting, although this does not necessarily mean within the first seven days of onset. A therapeutic dose of 4 c.c. was injected intramuscularly in cases of whooping cough, followed in two days by another dose of 4 c.c., the prophylactic dose in the fifteen contacts was 2 c.c. intramuscularly by single injection. Sensitivity tests were conducted on all members of the study group, and all were negative. Among the 110 individuals treated there were no untoward reactions.

cases classed as failures, three cases showed no improvement but were complicated by secondary infection, and eight cases, although showing no clinical improvement, were of comparatively short duration. Eight of the cases which did show definite improvement were followed, however, by complication. Of these eleven cases in which there was definite complication, eight were caused by secondary infection, two children had convulsions and one developed nasal hemorrhage. Clinical improvement in cough was noted in sixty-two cases, in vomiting in thirty-seven cases, and fifty-six individuals were reported to have slept better.

It is interesting to observe (Table II) that there

From the Detroit Department of Health.
*The antipertussis rabbit serum used in this study was provided by Wyeth, Incorporated.

†Testing this difference against the hypothesis that if the serum were of no benefit, the expected ratio of successes to failures would have been 1:1, shows this observed difference to be statistically significant.

were failures in seven cases (25.9 per cent) of those children who were given the serum before the disease had progressed seven days after whooping or vomiting, and in fifteen cases (22.0 per cent) of those in whom the disease had been established for a longer period. Statistical tests of reliability indicate that this difference is not significant and may be a chance finding. This would suggest that early institution of treatment plays little part in the outcome of the disease.

Of further note is that of the ninety-five children treated, there were three who had previously been immunized within a year and a half of the onset of the present illness. Two of these cases were considered failures.

It is particularly interesting to observe that there were no deaths in the ninety-five cases and fifteen contacts under treatment. Included here (Table I) are twenty-six cases and fifteen contacts under one year of age, in which group there exists a comparatively high case fatality rate.

Of fifteen contacts treated prophylactically, only six individuals (40.0 per cent) were prevented from developing pertussis. An individual four persons had a modified course, and the remaining five individuals developed a typical case of the disease. Obviously, the small number of persons treated prophylactically precludes any valid conclusions relative to such use of antipertussis rabbit serum.

## Conclusions

1. It is generally admitted that whooping cough is still a major cause of death among infants, and that the therapeutic approach to this disease leaves much to be desired.

2. Antipertussis rabbit serum has been advised by many to be one possible solution to this therapeutic problem. The present study conducted in Detroit, Michigan, in 1947 is an attempt to aid in the evaluation of the efficacy of this agent.

3. The results of this study, although there exists no specific control group, would suggest that antipertussis rabbit serum might prove an adequate agent in the management of whooping cough. It does indicate the need for further investigation under strictly controlled conditions in order to determine with finality its true therapeutic advantages.

The writers wish to express their appreciation to Dr. Joseph G. Molner, Deputy Commissioner and Medical Director, Detroit Department of Health, for his advice and guidance in conducting this study.

## FAMILIAL REPETITION OF MYELOMENINGOCELE

*(Continued from Page 727)*

spina bifida in the family, while Cutler[3] obtained a history of spina bifida or hydrocephalus in other siblings in three of his sixty-two cases. Sachs[8] refers to a family in which three successive children had spina bifida.

The reports cited would seem to indicate that spina bifida may be hereditary in certain families.

## Summary

1. A case of close familial repetition of myelomeningocele is reported.

2. The hereditary background of congenital malformations is discussed.

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MSMS

## CURARE PREPARATION RELIEVES SYMPTOMS OF ARTHRITIS

Curare is bringing relief to persons suffering from the painful chronic disease, rheumatoid spondylitis.

Use of the preparation, d-tubocurarine suspended in oil and wax, is reported by Bernard M. Norcross, M.D., and Harold M. Robins, M.D., of the University of Buffalo Medical School, Buffalo, N. Y., in the May 28 *Journal of the American Medical Association.*

In six cases in which the doctors administered the preparation after other treatment usually prescribed for the disease had failed to produce improvement, the patients were relieved of pain, their muscles were relaxed, deformity of the spine was corrected, and they were able to take more exercise.

Practically no toxic effects from use of the preparation were noted, the doctors say.

# Bon Secours Hospital Clinic Day

**Session of May 24, 1949**

## EXFOLIATIVE CYTOLOGY IN PERIODIC PHYSICAL EXAMINATION

**Donald G. Ross, M.D., and Nelson M. Taylor**

In 1864 a tumor of the bladder was diagnosed on the basis of urinary sediment examination, but Papanicolaou who first reported the detection of cancer cells in vaginal smears in 1928 has recently popularized the method. It has now received wide application in the hands of many investigators who have examined body fluids and available orifices with increasing degrees of accuracy. The literature includes three large series totalling more than 5,000 cases in which the interpretive errors vary from 4 per cent to 0.3 per cent.

A small series of 169 private patients studied by the authors during routine physical examinations included 182 smears. Vaginal smears accounted for the majority of the examinations, and in a group of 115 cases with 124 smears there were five positives for malignancy and three questionable reports. Obviously, all the patients who had no pelvic complaints were considerably disturbed. This is reflected by the fact that all but one of the five went elsewhere for further observation. One had a hysterectomy at another hospital where the diagnosis of carcinoma was not confirmed (serial histologic specimens were not run). Two patients had curettages elsewhere without confirmation; one received "routine" radium implantation. One sixty-one-year-old patient with a smear positive for epidermoid carcinoma was operated at Bon Secours Hospital. There were no gross lesions visible, but at curettage a small irregularity was noted in the fundus. However, when hysterectomy was done, this papilloma was found to be benign, but serial sections of the cervix disclosed carcinoma *in situ*s One eighty-year-old patient was advised by a radiologist elsewhere not to have any therapy.

The limitations of the test must be explained to the patient. Nevertheless, the simplicity of the test, its inexpensiveness without hospitalization, lack of discomfort to the patient, ease with which observations may be repeated and its increasing reliability in the hands of trained observers recommend it for routine use in periodic physical examinations.

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## EXFOLIATIVE CYTOLOGY—PATHOLOGICAL ASPECTS

**Joseph A. Kasper, M.D.**

In the past three years smears of exfoliated epithelial cells have been employed on a progressively widening scale for the diagnosis of early cancer. Since Papanicolaou first showed that this procedure can be highly efficient as a laboratory aid in the diagnosis of carcinoma of the uterus through studies of properly prepared smears of material obtained from the vagina and cervix, it was logical that its adaptation should extend to studies of sputum, prostatic fluid, urine and breast secretions. Swabs also have been employed for the procurement of material from suspicious lesions in the mouth and pharynx and the lower intestinal tract. In a surprisingly large proportion of cases, correct diagnoses resulted without subjecting the patients to procedures requiring hospitalization. It is unfortunate, however, that the lay press has succeeded in conveying the impression that the smear will of itself serve to establish the diagnosis of cancer. It is undeniable that as a screening procedure exfoliative cytology has its place in periodic examinations, as well as in instances where certain definite signs suggest the possibility of the development of malignancy, but it should be remembered that a negative report can give rise to a false sense of security. Moreover, the criteria upon which the pathologist's report is rendered are not always absolute indications of malignancy. Such cytologic abnormalities as hyperchromatism, abnormal mitosis, and variation in cell and nuclear size may occur under conditions of cellular regeneration without the existence or possible development of a malignant change, as in ulcers due to infection or chemical action. The smear showing abnormalities of cell structure, considered to be indicative of malignancy, is not to be taken by itself as diagnostic. It is always necessary to correlate the smear findings with more precise evidence of malignancy, preferably biopsy, curettment or bronchoscopic aspiration.

The smears must be fixed, while still wet, in equal parts of ether and 95 per cent alcohol. Thin spreads are essential. Thick deposits of material will render the study of individual cells very difficult or impossible.

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## DIVIDED DOSES OF PROTAMINE INSULIN IN SEVERE DIABETES

**T. H. Heenan, M.D.**

The goal we are striving for is the perfect control of the diabetic patient throughout the twenty-four hours of the day. Various methods of insulin administration in common use are discussed, their advantages and disadvantages.

The rational of the two-dose administration of protamine insulin is discussed, and the results of its use are shown.

The advantages are as follows:

1. It gives the physician three variables with which to work, i.e., diet and two separate insulin doses.
2. It avoids night insulin reactions.

3. It gives a more even and normal insulin absorption and utilization.

4. It gives a more even blood sugar level throughout the twenty-four hours.

5. It allows extremely large doses of one kind of insulin to be given.

6. It should lead to fewer complications.

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## HEART BLOCK

**Hugh Stalker, M.D.**

The *conduction of the impulse of the heart* may be blocked or slowed in one of four systems all intimately related. The *sino-auricular node* lies at the junction of the superior vena cava with the right auricle. The *A-V node,* which lies in the right auricle at the lower part of the interauricular septum, extends to the *Bundle of His* and passes to the upper part of the interventricular septum. The *right and left bundle branches,* each going to the corresponding ventricle, pass downward beneath the endocardium of the septum and give off primary branches to the papillary muscles. The strands divide into innumerable filaments to form the so-called *Purkinje fibers.*

The *blood supply* to the S-A node and the A-V node is the right coronary artery. The right bundle branch is supplied by the left coronary artery. The left bundle branch is supplied by both coronary arteries.

We think of normal rate as 60 to 90. It is important to remember that a heart rate in the forties and even in the thirties per minute at rest can be perfectly normal, particularly in athletes and especially distance runners. Pathological degrees of *sino-auricular bradycardia, block and arrhythmia* are rarely seen. They are most commonly produced by excessive doses of digitalis, quinidine sulphate, vagal irritation and obstruction of blood supply.

The electrocardiogram is the best method of demonstrating slowing or blocking. Treatment: omission of toxic agent and control of underlying cause. Treatment of marked bradycardia with faintness or syncope: atropine sulphate, epinephrine, ephedrine, cardiac massage and carotid denervation.

*A-V block* is a normal phenomenon in auricular fibrillation, auricular flutter and very rapid paroxysmal auricular tachycardia. Toxic and nervous influences and destructive lesions are the etiological factors for the pathology of this condition. Among other causes are extensive coronary disease, infarction of posterior wall, acute thrombosis of right coronary artery which supplies A-V junctional tissues, syphilis, diphtheria, rheumatic infection, vegetative lesions of bacterial endocarditis, congenital origin and I-V septal defects. The electrocardiogram shows prolongation of A-V conduction beyond 0.20 seconds. Treatment: discontinuance offending drugs and treat underlying cause. In rare cases when ventricular standstill is so frequent or of such long duration that dizziness, faintness, syncope or convulsions (Morgagni-Adams-Stokes syndrome) ensue, try ephedrine, gr. ⅜ to ¾ three to six times a day.

*I-V block and bundle branch block:* When block exists to moderate or marked degree in either of the right or left bundle branches, it becomes evident in the electrocardiogram and in no other way. It may be temporary, functional, or permanent and organic; coronary atherosclerosis, occlusion of a large coronary artery (more often right or left circumflex branch), rheumatic myocarditis (right bundle branch generally), syphilitic infection (gummatous or diffuse), acute diphtheria (bad prognosis), bacterial endocarditis, tumors, trauma and congenital (I-V septal defect). The signs are reduplication of one or both heart sounds. Treatment: direct treatment to underlying cause. If angina or heart failure occur, forget I-V block and treat the heart.

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## DEVELOPMENTAL CATARACT

**Cecil W. Lepard, M.D.**

Developmental or congenital cataracts arise from two causes: an inherited characteristic due to faulty germ plasm, or the result of maternal influences during the first three months of pregnancy. Recent reports of congenital cataracts and other anomalies occurring in the children of mothers who had German measles during the first three months of pregnancy is an example of this latter type. The association of congenital cataracts with other anomalies of the eye and also those occurring in other systems will be illustrated. Management consists in a diagnosis as to the type of congenital cataract and the determination of the extent of impaired vision. A colored movie was shown to illustrate the surgical procedure on those cases where operation is indicated.

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## ATROPHIC GASTRITIS

**Richard C. Connelly, M.D.**

Atrophic gastritis is the condition which exists when all elements which go to make up the stomach, the various types of glands and their supporting structures, undergo degeneration and reduction in size. The gastroscopic picture is characteristic. Digestive symptoms such as anorexia, indigestion, flatulence, sense of fullness or heaviness, constipation and diarrhea are at times apparently associated with this condition alone. Nutritional deficiency states with anemia, loss of muscle tone, loss of memory and inability to concentrate are frequently found with atrophic gastritis. Whether the nutritional deficiency states precede or follow the development of atrophy is debatable. Correction of the deficiency is not usually followed by restoration of function of the stomach. Clinical experience and recent investigative work indicates that in the presence of atrophic gastritis certain fractions of foods are not absorbed from the gastrointestinal tract.

## THE SWOLLEN LEG

Donald N. Sweeny, Jr., M.D.

The proper and effective management of any patient presenting himself with a swollen indurated leg requires a knowledge of the various factors which influence the lower extremity, an understanding of the many therapeutic measures which may be employed, and, what is more important, the realization that none of even the most minor pathological processes at work are static but are conditions whose factors will continue to operate over a period of time. Progression of lymphedema, and ultimately ulceration of the leg, is the rule. A swollen leg usually has more than one positive cause responsible for its development. Awareness of the many therapeutic measures, including embolectomy for the acute arterial or venous emergencies, sympathectomy for the more chronic difficulties or systemic medical measures, is essential. The proper management of each individual case is problematic and interesting; each offers a challenge which represents more than just dressing a leg ulcer or applying an Ace bandage.

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## NASAL RECONSTRUCTION

Bruce Proctor, M.D.

The term "nasal reconstruction" applies to the surgical correction of congenital and traumatic deformities of the external and internal nose. A better functioning nose is more likely to be obtained by combining accepted surgical techniques devised for deformities of the external and internal nose. In recent years, faulty concepts of nasal reconstruction have been corrected, existing methods improved and standardized, and new instruments devised. A great deal of study and research has been done concerning the proper relationship and conformation between the nares, olfactory sulcus and choanae. Many details have been worked out concerning peak positive and negative pressures, misdirected currents and regulating valves. The clinical application of these new physiological concepts has opened a new era in rhinological surgery.

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## RENAL NEOPLASM

Ira G. Downer, M.D.

Neoplasms of the kidney present a clinical problem of the greatest importance, in the matter of their deadly potentialities. They require early recognition and prompt therapeutic activity if lives are to be saved. Hematuria is the earliest symptom and may be present once and not recur for months. Hence, all hematurias should be explained at once by systoscopy and retrograde pyelography. Exfoliative cytology may help in diagnosis. Nephrectomy is the treatment. Radiation therapy is of little value.

## ABERRANT MAMMARY TISSUE

Harold B. Fenech, M.D.

The classification of congenital anomalies of the breast is discussed, and the literature is reviewed concerning several accounts of malignancy found in aberrant breast tissue.

A review of the records of Harper Hospital over a period of thirty years, which accounts for about 600,000 admissions, reveals only five cases of aberrant breast tissue; in none was a malignancy found.

This report is of two sisters, aged thirty-nine and forty, respectively. One has large, bilateral, aberrant breast tissue masses. This patient had ten children, and lactation occurred with each pregnancy. In this case, also, a cystic tumor was found in the left breast, which caused her to seek advice regarding care. Bilateral excision of the masses of breast tissue was performed.

The sister, a forty-year-old individual, has also had ten children and has bilateral masses of aberrant breast tissue; one side is quite large. Lactation has taken place in neither side. She submitted herself for examination but refuses to have the masses removed.

In reporting these cases, we are also pointing out that at Harper Hospital there has been no case of malignancy occurring in aberrant breast tissue during the thirty years of this review. Our experience would not uphold the findings of others that malignancy develops not infrequently in aberrant mammary tissue.

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## CANCER OF THE BREAST

Galen B. Ohmart, M.D.

Cancer of the breast is purely a local disease in the beginning. If left untreated it will disseminate throughout the body and will eventually bring death to the patient. If the lesion is diagnosed when it is a local disease, the patient can be completely cured by excision of the lesion.

Spread of the disease may be by extension through the lymphatics or by the blood stream. When this happens, complete cure is much less likely. Hence, early diagnosis is a very important thing. Every tumor of the breast should be removed by an excision biopsy, with a frozen section study and a radical removal done immediately if malignancy is found. This should be followed by deep x-ray therapy.

Athough results for complete cure are often disappointing if the disease has spread, some good results are obtained which give us hope, as the following case illustrates.

Mrs. S. P. aged thirty-one, had a tumor removed from her breast by an excision biopsy. A frozen section showed malignancy. The breast was removed by radical excision, and the glands in the axilla were grossly involved. This was followed by x-ray treatments. Fourteen months after her operation she delivered a full-term baby girl. Today, five and one-half years after her operation, she is alive and well with no evidence of a recurrence.

## RECTOURETHRAL FISTULA

**Jacob F. Wenzel, M.D.**

In 1913 in the *Transactions of the American Association of Genito-urinary Surgeons,* Young and Stone described a modified pull-through procedure to divert the fecal stream beyond the area of surgical repair in the correction of rectourethral fistula. Antecedent suprapubic cystostomy was used to divert the urinary stream from the operative site.

Diversion of the fecal stream and diversion of the urinary stream remain basically fundamental in the repair of rectourethral fistula.

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## ANEURYSMS OF THE ABDOMINAL AORTA

**E. Frederick Lang, M.D., and W. George Belanger, M.D.**

The diagnosis in this unusual disease is frequently made late. The usual etiological bases are arteriosclerosis and syphilis, although possible causes are trauma, direct invasion in bacteremia, and extension of contiguous destructive processes. Unruptured leutic aneurysm produces pain, while arteriosclerotic aneurysm is usually silent until late. Either type may be evident as a mass. The most serious complication is rupture, after which the symptoms depend upon the site, rate, and extent of the bleeding.

Radiological methods aid in diagnosis, either in demonstration of an unsuspected lesion or in confirmation of the clinician's suspicions. Pressure effects on the urinary tract, gastrointestinal tract or skeleton sometimes lead to the diagnosis. If the patient survives rupture, the clinical picture may be confusing while the roentgen changes are characteristic.

In the diagnosis of this disease in all its stages, the closest co-operation between the clinician and the radiologist is imperative.

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## SUBTOTAL GASTRECTOMY FOR PEPTIC ULCER

**William E. Abbott, M.D.**

The results of twenty cases undergoing subtotal gastrectomy for peptic ulcer are presented with emphasis on the pre-operative and postoperative care and the reasons why this operation is preferred to vagotomy.

Since a fairly high incidence of postoperative complaints (diarrhea and distention) was encountered in the author's limited experience with vagotomized patients, it seemed of interest to compare the immediate risk and the early results of this procedure with that of subtotal gastrectomy.

It has been fairly well established that when a vagotomy is done the mortality rate is extremely low and that the period of hospitalization is relatively short. However, because a moderately high incidence of postoperative complaints (incomplete vagus section, distention and diarrhea) has followed this procedure, it is felt that the present-day figures would show that the results and risk and the period of hospitalization following a subtotal gastrectomy are such that the latter operation is to be preferred.

In this series of twenty consecutive cases there were no deaths. In one case the results were poor, and in nineteen, good to excellent. The patients' stays in the hospital following subtotal gastrectomy ranged between four to nine days, with the exception of the one case in which the poor results were obtained. This one will be discussed.

While this series is small, it is believed that if careful attention is paid to the following items, the mortality rate and the speed of recovery of patients undergoing a subtotal gastrectomy should rival that seen in vagotomized patients and that the results would be preferable:

1. The preoperative dietary management includes electrolytes, vitamins, and protein, especially in obstructed and bleeding patients.
2. The restriction of sodium containing solutions.
3. An adequate gastric resection with emphasis being placed on care rather than speed.
4. The use of adequate quantities of blood.
5. The use of a nonabsorbable suture for the fascia.
6. Careful and repeated chest examinations with early ambulation and coughing.
7. *Nothing* by mouth postoperatively until peristaltic sounds are audible. Gastric suction and prostigmine as indicated.

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## TRICHOMONAS VAGINALIS VAGINITIS

**Robert G. Swanson, M.D.**

Leukorrhea is the most common and often distressing symptom among gynecological patients. Leukorrhea of vaginal origin is most often due to a vaginitis caused by the flagellate, trichomonas vaginalis. The innumerable variations in treatment are testimony of the lack of accurate knowledge concerning this distressing disease.

The disease occurs in any age group from puberty to the postmenopause and is most often associated with definite symptoms and characteristic clinical findings.

The diagnosis is often confused with gonorrhea, and careful differentiation must be made by use of the stained smear and the fresh wet smear.

Treatment is varied and with equally good results. In general, the principles as based on keeping the vaginal mucosa dry, maintaining the vaginal acidity at a normal level of 4.5 to 5.0, giving home therapy during the intervening menstrual periods and hygienic instruction on care of the perineum.

Variations in treatment must be considered when dealing with coexistent infections, pregnancy and the menopause.

Criteria for cure must be estabilised, and all recurrences must be reinvestigated for foci in the urethra or bladder. In this category one must consider the husband as a possible carrier.

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## MEDICAL ASPECTS OF JAUNDICE

**Herbert C. Allison, M.D.**

Jaundice is essentially a symptom of some underlying disease. If one understands the mechanism of jaundice along with symptoms produced, it is usually possible to

make a correct diagnosis of the underlying condition.

The hyperbilirubinemia that causes the yellow discoloration of skin and mucous membrances may be due to an over production of bilirubin.

1. Hemolytic jaundice is due to:
   (1) Hemolytic anemias.
   (2) Pernicious anemia.
   (3) Pulmonary infarct.
   (4) Poisoning.
2. Due to hepatic cell damage preventing proper secretion of bilirubin, intrahepatic jaundice:
   (1) Acute hepatitis.
   (2) Cirrhosis.
   (3) Pneumonia.
   (4) Syphilis (congenital).
   (5) Pregnancy.
   (6) Poisoning.
   (7) Mononucleosis.
   (8) Abscess.
3. Due to obstruction to bile flow, obstructive jaundice:
   (1) Cholelithiasis.
   (2) Carcinoma (bile ducts, gall bladder, pancreas, and papilla of Vater).

The symptoms and treatment of the first two types are primarily medical, while the third is of necessity surgical.

The scope of this paper will therefore confine itself to discussion of the first two types.

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## LABORATORY AIDS IN DIAGNOSIS OF SURGICAL JAUNDICE

**E. John Tamblyn, M.D.**

1. The problem of the practitioner: the differential diagnosis between hepatitis, including cirrhosis (medical jaundice) on the one hand, and extrahepatic biliary obstruction (surgical jaundice) secondary to stones, tumors, strictures, scars, adhesions.

2. Comments on the confusion existing regarding the value of laboratory tests in the diagnosis of jaundice and the reasons for same.

3. The laboratory tests used in the differential diagnosis of surgical jaundice. The two basic factors to be determined are (a) impairment of bile flow and (b) impairment of hepatocellular function.

(A) Tests to determine impairment of bile flow:
   (1) Absence of urobilinogen in the feces and urine.
   (2) Increase of serum alkaline phosphatase level.
   (3) Hypercholesteremia.

(B) Tests indicating liver cell dysfunction:
   (1) Quantitative changes in the total serum proteins, and the albumin and globulin fractions.
   (2) Qualitative changes in the plasma proteins.
      (a) Cephalin—cholestrol flocculation test.
      (b) Thymol turbidity test.
   (3) Cholesterol esters—(quantitative changes in).
   (4) Prothrombin time—changes in.
   (5) Changes in hippuric acid excretion.
   (6) Urobilinogenuria.
   (7) Renal pathology.

(C) Tests indicating both bile flow impairment and liver cell function:
   (1) Serum bilirubinemia—direct and indirect bilirubin.
   (2) Bilirubinuria.
   (3) Bromsulphalein retention.

(D) Liver biopsy.

## JMSMS

### DEPARTMENT OF GENERAL PRACTICE?

"Your inquiry relative to the establishment of a Department of General Practice in medical schools stems from premises that I must characterize as untenable. In my judgment, undergraduate medical education must perforce cover such a breadth of basic and clinical subjects as to preclude specialization. Its tenets should primarily assume preparation for the practice of general medicine. At least upon the foundation of a good medical education in a modern medical school, through a sound internship and subsequent experience fortified by periodic courses and regular attendance upon scientific meetings, a true practitioner of medicine will eventually emerge. In my judgment, our objectives in undergraduate medical education should be the sound preparation of the individual to become the family counselor in medicine.

"In my judgment, a separate Department of General Practice is a backward, rather than a forward, movement. Rather would I have a well-rounded and proved family counselor appointed to the staff of the Department of Medicine. By precept and example he will do infinitely more to advance general practice than in a separate department."—WILLIAM S. MIDDLETON, M.D., Dean, University of Wisconsin Medical School.

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## NEW DRUGS FOR ALLERGIC DISEASES

*(Continued from Page 726)*

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*10 Peterboro*

# Detroit Physiological Society

**Session of March 17, 1949**

## The Effect of Splenectomy in the Hemolytic Anemias

Frederick A. Coller and Alexander Blain, III, University Hospital, Ann Arbor, Michigan.

Hereditary spherocytic anemia and certain forms of acquired hemolytic anemia are prominent among diseases treated by splenectomy. The former is transmitted as a Mendelian dominant, and the basic abnormality appears to be an inherited variation in red cell structure (Microspherocytosis). Idiopathic acquired hemolytic anemia appears to be the result of chemical changes in the serum or of immune bodies acting upon the red cells. The role of the spleen in these syndromes is poorly understood, but clinical cures often follow splenectomy.

At the University Hospital, Ann Arbor, twenty-nine patients underwent splenectomy for hereditary spherocytic anemia in the period between July, 1934, and May, 1947. There were two hospital deaths (one from a transfusion reaction during a hemolytic crisis, and one from postoperative venous mesenteric thrombosis), and one death from unrelated causes. The remaining patients are clinically cured. None have anemia or jaundice as determined in a complete follow-up study. Eight of the twenty-nine patients had associated cholelithiasis. None had leg ulcers.

The acquired form of idiopathic hemolytic anemia, in contrast, does not provide as clear an indication for splenectomy, and the end results are poorer. In fourteen patients operated upon for this disease during the same period, five died. There was one anesthetic death, and one death six months postoperative from associated cirrhosis (the anemia having been cured). Three additional patients died eleven months, twelve months, and seven months postoperatively without relief, in spite of multiple transfusions, from their acquired hemolytic anemia. All nine living patients report that they are feeling healthy and well.

A comparison of the mortality and results in the hereditary hemolytic anemia (mortality under 7 per cent) and the acquired idiopathic hemolytic anemia (mortality 28 per cent) serves to emphasize the difference between the results to be expected from splenectomy in these two forms of hemolytic anemia.

## Spinal Cord Connections for Sensory Nerve Fibers from the Knee Joint of the Cat

Ernest D. Gardner, Wayne University College of Medicine, Detroit, Michigan.

Nerves to diarthrodial joints are distributed in a fundamental pattern. They vary in their course but, on reaching a joint, supply a rather constant region. Overlap is present so that each major region of a joint is supplied by at least two nerves. There are regional differences so that certain areas are more heavily supplied than others and contain proprioceptive type endings. Free nerve endings also occur in joint capsules, and in association with blood vessels, and come from smaller fibers of joint nerves.

Functions of joint nerves have been studied mainly in the cat and usually by electrophysiological methods. Results show that fibers giving off proprioceptive type endings enter the spinal cord and give collaterals which ascend in dorsal funiculi to the brain stem. Presumably this pathway is concerned with joint position sense. The same entering fibers also give collaterals to gray matter of several cord segments. Connections are established which result, in decapitate cats, in reflex activation of flexor muscles. In decerebrate cats, however, extensor muscles were occasionally involved as well. The movement patterns obtained in these experiments suggest that the above pathways are concerned in reflex control of locomotion.

Stimuli strong enough to affect smaller fibers, those forming free nerve endings, also result in reflex flexion and contralateral extension as well. Vascular and respiratory changes also occur, so that these are undoubtedly pain pathways.

In summary, articular nerves are concerned with the transmission of proprioceptive and painful stimuli. Anatomical evidence also indicates that

vasomotor and vasosensory fibers are present in the nerves.

### The Physiological Basis of Some Problems of Late Pregnancy

Clark Gillespie, Carnegie Institute of Washington, Baltimore, Maryland.

Complications of late pregnancy may arise from aberrations of physiological growth patterns of early pregnancy. Studies on litter-bearing animals revealed three distinct periods of uterine growth commencing with a period of preparation which consists of proliferation of the endometrium in preparation for nidation. Following nidation is a period of uterine proliferation which is characterized by hyperplasia of the myometrium, due mainly to the tension stimulus of the enlarging conceptus site. This tension reaches a critical point as growth at each site continues in a sperical shape until ischemia of the myometrium takes place. The tension is abruptly relieved at the onset of the third stage by rapid elongation or "conversion" of the uterus into a cylindrical shape. The ischemia is thereby reduced as is the stimulus for growth. Enlargement thereafter is accomplished mainly by elongation of myometrium already developed. Moreover, the fetus matures rapidly in this cylindrical uterus, and it seems that the maturity at birth of a given species is related not to the total length of gestation but to the relative time the fetus is in the uterus of the last or converted stage.

Primate uteri appear to follow a somewhat similar pattern. In Rhesus monkeys, elongation of the uterus from a basically spherical shape occurs about the one hundredth day. At this point there appears to be cessation of growth of the myometrium and its vasculature and enlargement thereafter is due to lengthening of these tissues and so imposes a limit upon the length of gestation.

Growth in the human uterus diminishes about the twenty-fourth week. This appears to coincide with a change in the shape of the organ and with an increase in the maturation rate of the fetus. The cessation of growth of the myometrium and its vessels constitutes certain limits on gestation. Further, failure of normal growth of these elements before the twenty-fourth week may be demonstrated late in pregnancy by inability of the uterus to accommodate the products of conception and further by the onset of placental ischemia which is believed to be related to the late toxemias.

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## Session of April 14, 1949

### Effects of Anterior Pituitary Growth Hormone Preparations on the Glutamine-Glutaminase System

Paul D. Bartlett and Oliver H. Gaebler, Edsel B. Ford Institute for Medical Research, Henry Ford Hospital, Detroit, Michigan.

Van Slyke et al (J. Biol. Chem., 150:481, 1943) have shown that transport and storage of ammonia are physiological functions of glutamine. Storage of amino nitrogen might be another function, and, in this respect, glutamine might be considered a major constituent of Schoenheimer's "metabolic pool" of nitrogen. Since in this and other laboratories, weight gain and nitrogen storage have been produced in rats and dogs with growth hormone preparations, it seemed of interest to study the *in vivo* effect of the recent Fishman, Wilhelmi, and Russell preparations on the glutamine-glutaminase system.

Kidney glutaminase assays, according to the method of Archibald (J. Biol. Chem., 154:657, 1944) were made on *ad libitum* fed twenty-six to twenty-eight day-old hypophysectomized rats, on hypophysectomized rats treated with 10 mg. of growth hormone preparation, and on normal rats. Values of 19.1, 30.6 and 35.2 units of glutaminase per ml. of 25 per cent kidney emulsion were obtained.

Studies conducted on hypophysectomized rats at approximately 1/20 of the dose level employed in the first experiments resulted in the production of a 27 per cent increase in body weight but no change in kidney glutaminase. Kidneys from the hypophysectomized controls assayed at 19.7 units per ml. of 25 per cent emulsion, and kidneys from the paired-fed hypophysectomized treated rats assayed at 19.9 units per ml. of 25 per cent emulsion.

Effects of growth hormone on plasma glutamine levels, determined by the method of Archibald, were studied on adult female dogs weighing from 15 to 18 kilograms. Elevations in plasma gluta-

*(Continued on Page 738)*

# Michigan Medical Service

Michigan Medical Service, the outstanding American plan of medical care, was conceived and is administered by Americans, for Americans.

It is American because it is voluntary with no element of compulsion, no interference with private initiative, no reduction of self-respect, and no subservience to the politician. It does not set up rules and regulations governing methods of selection and of treatment by doctors. There is no interference with patient-physician relations.

Over one half of its Board of Directors are doctors of medicine, citizens who know the problems and needs of supplying medical care and who have the scientific knowledge necessary to develop adequate programs of benefits.

Michigan Medical Service has developed by trial and error the actuarial data covering the costs of medical care. It knows what to expect in demands for medical services from its subscriber groups. It is so efficient in management that over 88 cents of the subscriber's dollar is returned to him in services rendered by our doctors. It has the knowledge and know-how so that all our citizens can be protected against medical costs. It developed the home-town care of veterans with service-connected disabilities, thus supplying a much needed service at a minimum cost. It has developed plans and can readily include the indigent in its program of protection against the unpredictable costs of health service.

Michigan Medical Service is true protection against those costs of catastrophic illness which might prove a financial burden to its subscribers.

There is but one criticism: not enough people are covered by this type of medical service. A rapid expansion in enrollment to blanket at least one half of our population would entirely eliminate any demands for a governmental, politically controlled, scheme of medical care.

Doctor, this is a challenge to YOU. Do your important part among your patients, your friends, your community to help increase the total subscribers in this potent answer to socialized medicine which you helped to create—Michigan Medical Service.

E. F. Sladek, M.D.

President, Michigan State Medical Society

President's

Page

**Anterior Pituitary Preparations**

*(Continued from Page 736)*

mine of 19, 30 and 33 per cent above the average control level were obtained. Nitrogen storage and weight gain were produced and excretion of urinary ammonia paralleled changes in the level of plasma glutamine. The inverse relationship of total urinary nitrogen excretion to the plasma glutamine level favored the interpretation of a functional role for glutamine in the interum storage and transport of amino nitrogen. In a final experiment, however, in which both the plasma glutamine amide nitrogen and the total 2-amino acid carboxyl nitrogen were determined, it was found that changes in glutamine amide nitrogen did not in any instance account for changes in the total free 2-amino acid carboxyl nitrogen or for the nitrogen stored.

Results of these experiments seem to indicate that the protein anabolic effects of the growth hormone are not due to direct effects on the glutamine-glutaminase system. Glutamine, however, does appear to be involved secondarily in nitrogen storage and subsequent catabolism.

**The Liver Glycogen Concentration in Fasted Alloxan Diabetic Rats**

Yoshikazu Morita and James M. Orten, Wayne University Medical School, Detroit, Michigan.

Low liver glycogen concentrations have been considered characteristic of diabetes mellitus since the days of von Mering and Minkowski. It has been found in our laboratory, however, that the glycogen concentration in the liver of the alloxan diabetic rat fasted for twenty-four or forty-eight hours is significantly higher than that of the correspondingly fasted normal control rat. One possible explanation for this finding may be the elevated blood sugar of the diabetic animals. The increased glucose concentration may shift the equilibrium of the reactions involved in the direction of glycogen synthesis. In support of this explanation is the finding of a significant, moderately high positive correlation between liver glycogen concentration and the logarithm of the fasting blood sugar value in the twenty-four-hour fasted alloxan diabetic rat. That the adrenal glands are also involved is indicated by the hypertrophy of the adrenal cortex in alloxan diabetic rats, and the disappearance of the high liver glycogen values in the twenty-four-hour fasted alloxan diabetic rat after bilateral adrenalectomy. Another factor which may contribute to the elevated liver glycogen concentration is the polyphagia exhibited by diabetic animals. However, even on a severely restricted food intake, the liver glycogen content of the alloxan diabetic rat after a twenty-four hour fast is still higher than that in the normal fasted animal.

**The Effect of Dietary Fat and Carbohydrate on Diethylstilbestrol Induced Mammary Cancer in the Rat**

W. F. Dunning, M. R. Curtis and M. E. Maun, Wayne University College of Medicine, Detroit Institute of Cancer Research, and St. Mary's Hospital, Detroit, Michigan.

The effects of dietary fat were assayed under conditions of controlled caloric intake by placing eigthy-four A x C Line 9935 female rats, with diethylstilbestrol pellets implanted in their scapular regions, on isocaloric synthetic rations of varying fat and carbohydrate content. Diets adequate in protein, minerals and vitamins, varying in fat content from 6.5 to 46.0 per cent, with sufficient dextrin to equalize the caloric content, were fed *ad libitum* and restricted to rats in individual cages. The caloric consumption varied from 40 calories daily for rats on the *ad libitum* high fat diet to 34 calories for those on the *ad libitum* low fat diet and their paired mates on the high fat diet, and was restricted to 25 calories in isocaloric portions of high fat, modified low fat, and low fat diets.

Of the sixty-seven rats which survived for at least 180 days, fifty-eight (87 per cent) developed 236 gross and 337 microscopic adenocarcinomas of the mammary gland. Restricting the caloric intake by 26 to 38 per cent of the *ad libitum* consumption did not decrease the percentage of rats which eventually developed mammary cancer, but increased the latent period from approximately 300 to 400 days.

More tumors were observed in a shorter average latent period in rats on a high fat diet than in their paired mates. Increased consumption of the high fat diet, however, lessened rather than enhanced these differences, and the only consistent effect appeared to be an accelerated growth potential in the preformed cancer cells.

Supported in part by a grant-in-aid from the United States Public Health Service.

# Editorial

## DESCENDANTS OF HIPPOCRATES

To the Michigan Descendants of Hippocrates, Greetings: May you never betray your obligations to mankind.

ONE HUNDRED years ago, Michigan formed its first medical society. We are proud of the record.

Ten years ago the state society developed Michigan Medical Service and lent its support to Michi-

R. L. Novy, M.D.

gan Hospital Service, the Blue Shield and the Blue Cross of Michigan. We are proud of the record. Will future history be proud of the way we will continue to discharge our obligations in this great movement? Ten years of action, not platitudes, should answer any doubting Thomas. The times call for your participation, not procrastination.

Ten years ago there was developing a bitter war of words and threats between those who would socialize medicine and the stand-patters. This war continues, with twelve points on one side, presidential campaign speeches on the other, while steadily down the road with its objective clearly in view march the Blue Cross and Blue Shield, the only positive action amidst all the hubbub.

You may well be proud of Michigan leading the vanguard for the rest of the country— thirty-three million people covered in the United States by the Blue Cross and eleven million covered by the Blue Shield, the doctors' own plan, conceived and executed by the doctors for the good of mankind.

While the battle of words continues, the Blue Shield plans have increased their enrollment 43 per cent in the past year. The public trust assumed by the medical profession continues to find favor throughout the nation; results speak louder than words. Experience by trial and error can answer a panacea sold under the carbide lamps of a presidential campaign.

Let each and every one of us remember where we stand. The Blue Shield movement throughout the country is the doctors' answer to the problem of the day. Back of every Blue Shield stands the county and the state organizations of the medical profession, controlled by the profession, administered through the profession, and executed by the profession. It represents action by the medical profession in contrast to platitudes and forensic displays.

It is my hope that every doctor in the State of Michigan will put his shoulder to the wheel and save his breath for the job at hand. You owe it to society and to yourself. While Rome burns, Nero fiddles! —Robert L. Novy, M.D.

## NATIONAL SOCIALISM

### Who are the Socializers?

THE COMMITTEE on Research in Medical Economics was established by Michael M. Davis, Ph.D., formerly director of Medical Services of the Rosenwald Fund, with a gift of $165,000 received from his former employers. He is still actively directing this committee with headquarters at 1790 Broadway, New York City.

The Committee for the Nation's Health, Channing Frothingham, M.D., chairman, was organized in 1946 by Michael M. Davis as an organization "to force the administration's health bills through the 79th Congress." Davis is the dom-

inating head. On the Board of Directors are John J. Corson, formerly of the Social Security Board, and an associate of Arthur J. Altmeyer; Mrs. Albert D. Lasker, New York; Ernst P. Boas, M.D., present or past member of several Communist-front organizations; Anna M. Rosenbery, New York, also associated with Altmeyer, and a member of the Social Security staff for many years; Mrs. Gardner Cowles, wife of the owner of the Register and Tribune Company, Des Moines, Iowa. The Committee for the Nation's Health is reputed to be financed by Marshall Field, Mr. Lessing Rosenwald, Adel Rosenwald Levy (Mrs. David), Albert D. Lasker, Mr. and Mrs. Gardner Cowles, et cetera. These were prime movers in Oscar Ewing's National Health Assembly, Inc., of 1948.

The Physicians Forum, Inc., has Ernst P. Boas, M.D., as chairman, is a larger and very vocal organization, working with the rest of the crowd who for thirty years have been trying to nationalize (as they call it) medicine.

Michael M. Davis, Isadore S. Falk, Arthur J. Altmeyer, Wilbur J. Cohen, and Ernst P. Boas, M.D., are the outstanding movers. Associated with them later have been Oscar R. Ewing and J. Donald Kingsley, his assistant. Many other names could be added to the list, but these are the names and the organizations we are going to hear about in the forthcoming campaign to save all of us from National Socialism.

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## THE PROGRAM

THE EIGHTY-FIRST Congress has before it S.5 and H.R.783, the old Wagner-Murray-Dingell bill reintroduced with no changes—also a bill introduced April 25, S.1679, H.R.4312, and H.R. 4313.

This is sponsored by Senators Murray, Wagner, Pepper, McGrath, Chavez, Taylor, Thomas and Humphrey, and Congressmen Dingell and Biermiller. This is reported to be over 163 pages, and is the Administration Bill. Comments are on Page 684.

Two other bills are before the Congress: S.1456 was introduced March 30 by Senators Lister Hill (*D.* Ala), O'Conor (*D.*Md.), Withers (*D.*Ky.), Aiken (*R.*Vt.), and Morse (*R.*Ore.). S.1581 was introduced April 14, 1949, by Senator Taft (*R.*-Ohio), Smith (*R.*N.J.), and Donnell (*R.*Mo.). These are both grants-in-aid bills, which would stimulate voluntary, nonprofit health insurance plans, and would help the states to work out their own health programs with Federal assistance. S.1456 we outlined last month. S.1581 we have not received at this writing, but Senator Taft has this to say:

"The bill . . . seeks to apply the best knowledge at our disposal to the vast problem of promoting the health of the American people. This problem is composed of many factors, some of which, such as income levels and habits of living, are entirely beyond the reach of specific health legislation. Others, however, can, to a great extent, be guided or stimulated by law without violating our American traditions of personnel, and the degree to which professional, medical and hospital services are actually within reach of the people generally. It is with such manageable factors as these that we seek to deal in this bill."

The House also has two bills for consideration. H.R.2892 proposes that the Government enter the field of medical assistance, and H.R.2893 would increase the present old age and survivors insurance. It would compel self-employed persons (physicians, lawyers, writers, shop keepers) to pay an additional income tax amounting to 2.25 per cent, in addition to all other taxes.

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## THE MEANS

EVERY PRESSURE measure has been used to condition the people to the so-called "fact" that the health of the American people is rotten. Draft figures were wrongly quoted. Millions of government money and thousands of government employes have been used to further the cause of socializing medicine. Oscar Ewing called a National Health Assembly and misused its report in his "Report to the President," advocating the very thing his own inspired organization refused to endorse.

Some months ago we reported the suit against the Oregon State Medical Society and the Oregon Physicians Service under the Sherman Anti-trust Law, charging restraint of trade. We have been informed that other medical societies are being investigated, and at the Blue Cross-Blue Shield Conference in Hollywood Beach, Florida, the report was made that the FBI men came into a Chicago Medical Society office, demanding their books for the past six years.

*(Continued on Page 758)*

# Who's Who in MSMS

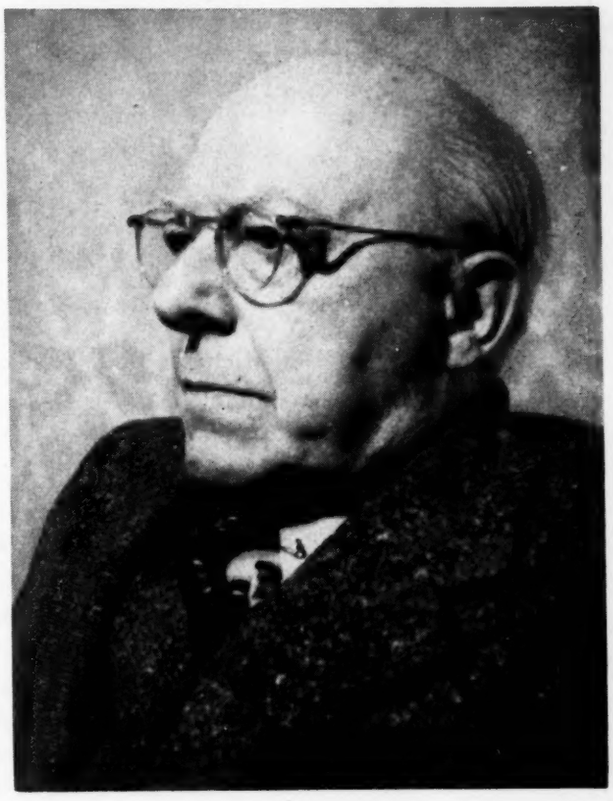
No mention of the accomplishments of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY would be complete without noting the long-time contribution of James Herbert Dempster, M.D., Detroit's beloved physician, who guided the book through the mercurial years of 1928 through 1938.

Dr. Dempster, emeritus professor of roentgenology of Wayne University College of Medicine, received his degree in medicine from this same school in 1909.

Dr. Dempster came to the editorship of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY in 1928 after many years of lay and medical editorial experience. He had been assistant editor of the London, Ontario, *Advertiser,* 1900 to 1912, and editor of the *Windsor Daily Record,* 1902 to 1905, and later, editor of the *Detroit Medical Journal* over eleven years, from 1909 to 1920. Dr. Dempster for years has been interested in medical history and has published numerous articles of high literary value on the subject of prehistoric diseases. He also has worked on medical history, especially of the Beaumont times and works.

In 1930 a *Medical History of Michigan* was published under the auspices of the Michigan State Medical Society, with C. B. Burr, M.D., as editor. In this two-volume opus Dr. Dempster prepared much of the text about William Beaumont, and much of the other text was gleaned from the *Pathfinders of Physiology* published by the Detroit Medical Journal Company in 1914, an excellent book by J. H. Dempster, who also wrote and published a text on medical writing. The chapters on medical education and on the first Michigan territorial medical society in the *Medical History of Michigan* are the work of Editor Dempster.

Dr. Dempster always has been a staunch defender of American medicine in its voluntary form—many of his editorials berating the almost constant attempts to socialize medicine, made even in the Torrid Twenties and the Prostrate Thirties. Indicative of his attitude is this quotation from a recent letter in which he said: "I think you will find on record enough that I have written editorially against socialized medicine that, should totalitarian socialism ever be the order of the day in the U.S.A., my words would entitle me to first place before the firing squad or an igloo on the icy waters of Nova Zeubla."



J. H. DEMPSTER, M.D.

Some of the principal subjects discussed in THE JOURNAL columns during Dr. Dempster's decade in the editor's chair were those concerned with the Basic Science Law, the report of the National Committee on the Costs of Medical Care, and the development of the postgraduate training program for Michigan physicians.

Michigan medicine will forever be indebted for the years that Detroit's Dr. Dempster so unselfishly gave to it. His was the hand that guided THE JOURNAL through ten perilous years of the great depression. To Emeritus Member Dempster the Michigan State Medical Society expresses sincere thanks for the legacy he bequeathed to his profession.

# Michigan Medical Service

Chicago, Illinois
May 2, 1949

Wilfrid Haughey, M.D.
Editor
Journal of Michigan State Medical Society
610 Post Building
Battle Creek, Michigan

Dear Doctor Haughey:

The devotion of this issue of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY to the affairs of Michigan Medical Service indicates a realization of the relationship between Blue Shield and the practice of medicine. The time is past, if indeed it ever existed, when the responsibility of the physician is limited to providing medical care. He must now offer a solution for the economic problems of medical care. He alone can do this without revolutionizing the pattern of medical practice which has brought the world capital of medicine to the United States.

In this evolution of medical thought, Michigan has been in the forefront. This is why Michigan Medical Service was the first Blue Shield Plan to reach an enrollment of a million members, and why it is regarded as a keystone of the entire Blue Shield structure.

With admiration for both the Michigan State Medical Society and Michigan Medical Service, I am

Most sincerely,

PAUL R. HAWLEY, M.D.
*Chief Executive Officer, Blue Cross-Blue Shield Commissions*

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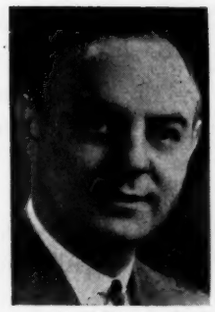

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# History of Michigan Medical Service

MICHIGAN MEDICAL SERVICE is the outgrowth of studies begun early in the 1930's by the Michigan State Medical Society and by various county medical societies in Michigan. The studies included an examination of the British panel system by representatives sent to England for that purpose. It was necessary to secure enabling legislation in Michigan, however, before the program could be put into operation. This legislation was passed during 1939, and Michigan Medical Serivce began operation on March 1, 1940.

It first offered a complete medical care program, covering medical services rendered in the patient's home, the doctor's office and the hospital. The objective of the doctors of Michigan, in other words, was to provide a medical program that was complete in every respect.

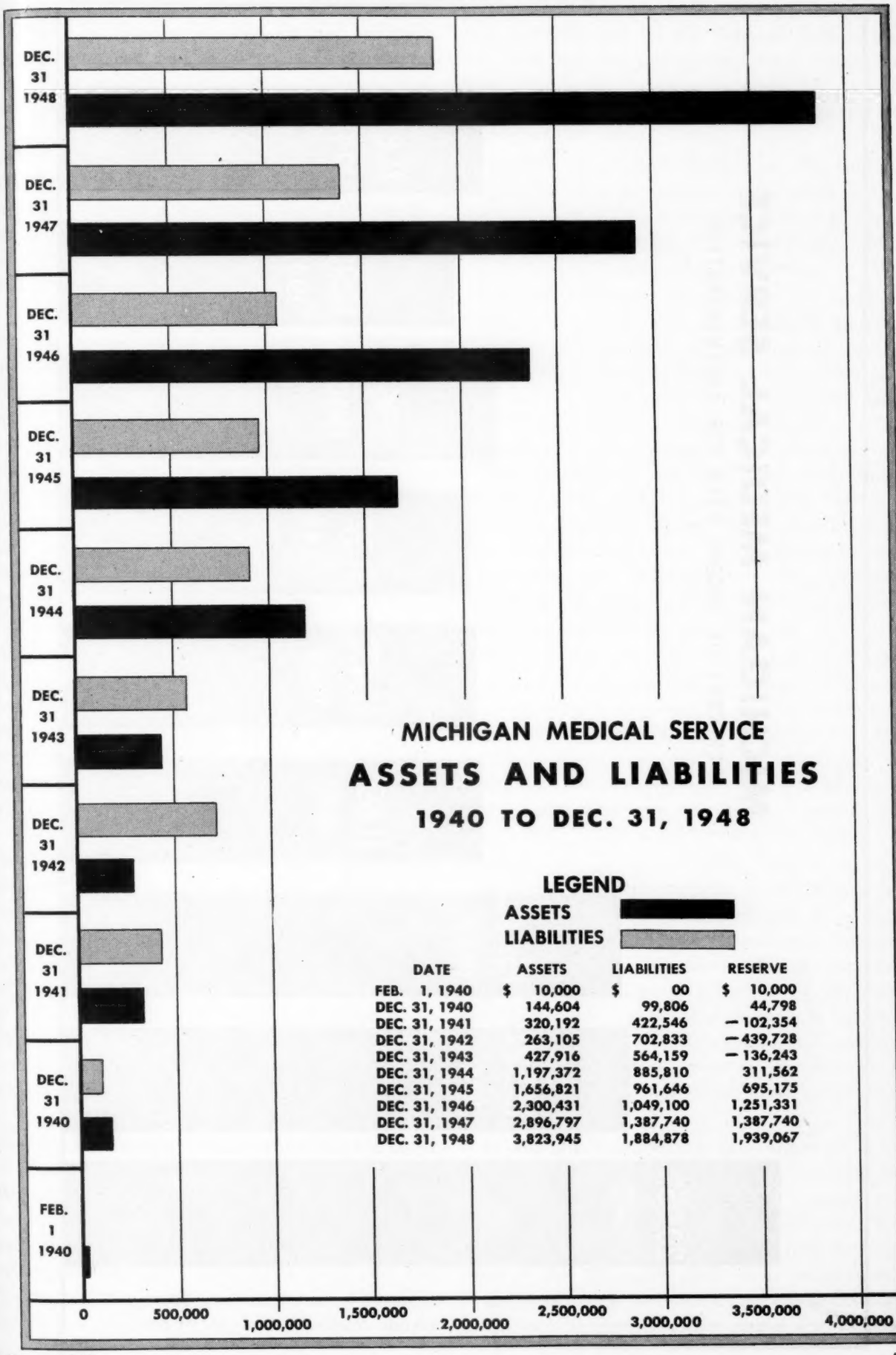
In the absence of actuarial data, the rate for this complete medical care program was set at $4.50 a month for a full family—a figure which proved to be barely half the actual cost of providing service to the average family at that time. In spite of this half-cost figure, the program attracted only negligible public interest. There developed almost immediately a considerable public pressure for protection against the costs of only major illness, and in response to this pressure Michigan Medical Service developed a program providing for surgical care in hospital cases. In twenty-seven months more than 350,000 persons were enrolled for this limited or surgical protection. During the same period of time, the maximum number enrolled under the complete medical care program was only 7,375 persons. Because of lack of public interest, the complete medical care program was discontinued in June, 1942.

It is, however, still the intention of Michigan Medical Service to broaden coverage as rapidly as there is evidence of adequate public interest. In order to determine public interest, a survey utilizing scientific sampling methods and involving personal interviews with nearly 5,000 persons throughout Michigan was undertaken during June and July of 1944. The survey showed that the people had definite interest in a program providing for medical care as well as surgical care in hospital cases, and Michigan Medical Service consequently has developed added protection of this type. The survey also showed that the residents of Michigan still were not interested in a program covering doctor's services in his office and in the patient's home. On September 1, 1948, however, all certificates were liberalized providing for surgical care in doctors' offices and out-patient departments of accredited hospitals, where the fee, in accordance with Michigan Medical Service Schedule of Benefits for such surgical procedure, is $20 or more.

Michigan's complete medical care program was offered, as has been shown, at barely half cost and was discontinued because of lack of public interest. Rates for the surgical care program were established to cover twice the amount of surgery that is normally required by the Michigan population. At one time, however, the amount of surgery required by Michigan Medical Service subscribers was nearly four times the normal requirement, and two upward rate adjustments consequently were necessary. The deficit experienced by Michigan Medical Service reached a maximum of $504,000 in 1942 and imperiled the operation of the entire program until changes in rates and in procedures brought about liquidation of the deficit and the strong financial position which Michigan Medical Service enjoys today.

While it maintains a separate corporate entity, Michigan Medical Service has joined with Michigan Hospital Service, the Blue Cross Plan providing for hospital care, in the development of a joint health care program. Thus the subscriber enrolls simultaneously for hospital, surgical and medical care, makes single regular payments, and carries a single identification card which, upon display to the doctor and to the hospital admission clerk, procures service for the subscriber.

In Michigan, Michigan Hospital Service and Michigan Medical Service are known to the general public and doctors as the "Blue Cross Plans." Nationally, "Blue Cross" indicates voluntary, nonprofit *hospital service* organizations like Michigan Hospital Service. Nationally, in the last few years, voluntary, nonprofit medical-surgical plans have adopted the term "Blue Shield" to designate such plans as Michigan Medical Service. In Michigan,




## MICHIGAN MEDICAL SERVICE

## ASSETS AND LIABILITIES

### 1940 TO DEC. 31, 1948

**LEGEND**

ASSETS

LIABILITIES

| DATE | ASSETS | LIABILITIES | RESERVE |
|---|---|---|---|
| FEB. 1, 1940 | $ 10,000 | $ 00 | $ 10,000 |
| DEC. 31, 1940 | 144,604 | 99,806 | 44,798 |
| DEC. 31, 1941 | 320,192 | 422,546 | — 102,354 |
| DEC. 31, 1942 | 263,105 | 702,833 | — 439,728 |
| DEC. 31, 1943 | 427,916 | 564,159 | — 136,243 |
| DEC. 31, 1944 | 1,197,372 | 885,810 | 311,562 |
| DEC. 31, 1945 | 1,656,821 | 961,646 | 695,175 |
| DEC. 31, 1946 | 2,300,431 | 1,049,100 | 1,251,331 |
| DEC. 31, 1947 | 2,896,797 | 1,387,740 | 1,387,740 |
| DEC. 31, 1948 | 3,823,945 | 1,884,878 | 1,939,067 |

MICHIGAN MEDICAL SERVICE
PER CENT OF INCOME PAID FOR ADMINISTRATION
20.05%
1940
15.52%
1941
15.44%
1942
11.69%
1943
11.43%
1944
11.32%
1945
11.96%
1946
10.99%
1947
11.81%
1948

Michigan Medical Service had adopted the term "Blue Cross" and had so called itself before the term "Blue Shield" was suggested. Michigan Hospital Service and Michigan Medical Service, therefore, in the early days of prepaid plans, adopted an emblem which is a combination of the national Blue Cross emblem and Blue Shield emblem. The Michigan emblem is the Blue Cross, deleting the emblem of the American Hospital Association and superimposing the shield and caduceus of the Blue Shield.

Thus far, the great majority of subscribers to the Michigan program are employes in business and industrial establishments. Several years ago Michigan Medical Service and Michigan Hospital Service began experiments and research, looking toward the opening of enrollment to every resident of the state who wishes this protection.

For the enrollment of farmers a very active program is under way. Over 650 farm groups already have been enrolled through Farm Bureaus, Granges, farmer co-operatives and the Farm Security Administration.

For the enrollment of the self-employed and others who do not belong to an eligible group, Michigan Medical Service and Michigan Hospital Service have a program of community enrollment through which interested persons in practically every part of the state, periodically, are given the opportunity to obtain protection through these two organizations.

For persons who cannot afford to pay, Michigan Medical Service and Michigan Hospital Service are seeking a means of co-operating with the government, whereby "wards of government" and the indigent will not be segregated in charity facilities but will be entitled to the same sort of service as any subscriber and, for all practical purposes, will be indistinguishable from subscribers paying their own way. The program providing for the care of veterans in service-connected cases offers a suggestion as to how this objective may be realized.

The existence of Michigan Medical Service provided a convenient means for meeting the needs of veterans with service-connected disabilities. In Michigan, thousands of such veterans have been permitted to go to their own physicians rather than to a veterans facility for examinations or treatments. Michigan Medical Service pays the doctors for these cases just as it makes payment for services provided to regular subscribers, and in turn, is reimbursed by the Veterans Administration. Not only has this system helped relieve the great pressure on veterans facilities, but it also has made it much easier for many veterans to receive needed care.

In addition, Michigan Medical Service could, in conjunction with government, offer relief recipients and welfare clients the same sort of personal service as that being provided to Michigan Medical Service subscribers and to veterans.

The administration and operation of a medical-surgical care plan is much more complex than the operation of a hospital care plan because of the wide variety of services that must be covered and the number of persons (doctors of medicine) who must render individual services under the plan. A hospital care plan provides for relatively few services offered by relatively few institutions, whereas a medical care plan encompasses hundreds of services offered by thousands of individual doctors. The problem of the medical-surgical plan is, therefore, that of gaining actuarial experience covering a wide range of services and of arranging for the participation of many doctors.

While it was not the first medical care plan sponsored by the medical profession, Michigan Medical Service happened to develop procedures which have made it the most successful of the doctor-sponsored nonprofit medical plans now in operation. The procedures developed in Michigan consequently have been accepted as a pattern for many other plans now operating or being organized.

Michigan Medical Service, as of March 31, 1949, had 1,329,044 subscribers and, as of that date, had paid $34,653,626.04 to doctors for services provided in 575,574 cases. One of every five residents of Michigan is protected by the plan, and the growth in number of subscribers last year alone amounted to 376,280 persons. It is expected that Michigan Medical Service will protect a great majority of the people of Michigan within the next few years.

Michigan is a single state and cannot speak for the balance of the nation. However, it is believed that the grass roots approach, which is highly sensitive to public demand and local requirements, has been fundamentally responsible for the development of the Michigan plan. It is characteristic of the more or less spontaneous growth of developments such as these that they spread very rapidly,

## MICHIGAN MEDICAL SERVICE

DETROIT, MICHIGAN

ENROLLMENT MARCH 1949

| | |
|---|---|
| SUBSCRIBERS | 1,329,044 |
| CONTRACTS | 533,745 |

STATISTICS

MARCH 1949

AMOUNT PAID FOR SERVICES

| | |
|---|---|
| VETERANS CARE | $ 94,716.25 |
| ALL OTHERS | $ 573,952.58 |
| TOTAL | $668,668.83 |

YEAR 1948

AMOUNT PAID FOR SERVICES

| | |
|---|---|
| VETERANS CARE | $1,023,468.87 |
| ALL OTHERS | $ 6,102,443.37 |
| TOTAL | $ 7,125,9 2.24 |

IN 1948 OUR INCOME DOLLAR WAS SPENT AS FOLLOWS :

| | |
|---|---|
| FOR SERVICES RENDERED | 84¢ |
| FOR ADMINISTRATION | 12¢ |
| FOR RESERVE | 4¢ |

GRAND TOTAL PAID TO ALL DOCTORS YEAR 1940 THRU MARCH 1949 $34,653,626.04

INCIDENCE OF SURGICAL SERVICE PER 1000 MEMBERS PER YEAR

| | | |
|---|---|---|
| 1940 | 162 | |
| 1944 | 107 | |
| 1948 | 127 | 1ST SIX MONTHS |

NUMBER OF SURGICAL CASES

| | |
|---|---|
| 1940 | 7,625 |
| 1941 | 21,152 |
| 1942 | 48,388 |
| 1943 | 53,397 |
| 1944 | 66,844 |
| 1945 | 84,660 |
| 1946 | 88,391 |
| 1947 | 99,734 |
| 1948 | 106,383 |
| TOTAL | 576,574 |

MICHIGAN MEDICAL SERVICE WAS THE FIRST BLUE SHIELD PLAN IN THE UNITED STATES TO ENROLL ITS

1,000,000TH SUBSCRIBER

THE LARGEST BLUE SHIELD PLAN IN THE WORLD

with each locality throughout the nation borrowing the best features of local accomplishments elsewhere. Thus, a number of the features of the Michigan program have been adapted elsewhere in the nation, just as the Michigan program has borrowed the successful features of similar plans in other parts of the country.

A number of the early medical care plans met failure or only moderate success. Michigan Medical Service is one of those which enjoyed such rapid progress that it has helped to establish positive proof that a voluntary medical-surgical care plan under sponsorship of the medical profession is practical and is preferred by the people.

From our experience in Michigan, we are certain that a true spirit of co-operation between voluntary health care organizations and governmental health agencies can produce for the nation the most effective, enduring and progressive system of health care. Voluntary health organizations should not attempt to do the whole job any more than should government attempt to do so, for the reason that any monopoly of health services, whether economic or otherwise, inevitably will lead to degeneration of the entire system. For greatest continued progress, it is imperative that there be maintained the sort of health care system which is characterized by a proper spirit of competition and by the existence of natural balances and checks in the best American tradition.

# Michigan Medical Service Enrollment

*The fundamental principle of Blue Cross and Blue Shield has been group enrollment. By that method no one would have to pay unusually large charges for their health services because the American principle of insurance would be applicable immediately. By a coincidence the first large group to take Michigan Medical Service benefits were the employes of the Ford Motor Company, and this same group when it re-enrolled increased our membership over the 1,000,000 mark.*

### Enrollment in Industry

With enrollment of the Ford Motor Company in November, total enrollment of Michigan's Blue Cross increased 27.5 per cent during 1948 and brought membership past the 1,500,000 mark.

In addition to the Ford group, 932 other new industrial, Farm Bureau and business groups—or an average of seventy-five groups a month—were enrolled. Among these were Eastern Airlines, the Wettlaufer Manufacturing Company, the Bendix Aviation Corporation, the Flint Trolley Coach Company and the employes of the City of Allegan.

Through the new subscribers in these groups, 41,650 persons are protected under the hospital care plan, 29,400 persons have the hospital-surgical protection, and 9,800 persons are protected under the hospital-medical-surgical plan.

Although there is a 75 per cent requirement for enrollment of groups in the surgical and medical-surgical plans, there is greatly increased interest in these plans. In consequence, the surgical plan was made available for the first time in 528 groups previously enrolled for hospital service only. As result of enrollment of these 528 groups in the hospital-surgical plan, 26,950 persons now have the additional surgical protection. A number of these groups also added the medical-surgical plan, making 18,510 persons eligible for the medical-surgical protection.

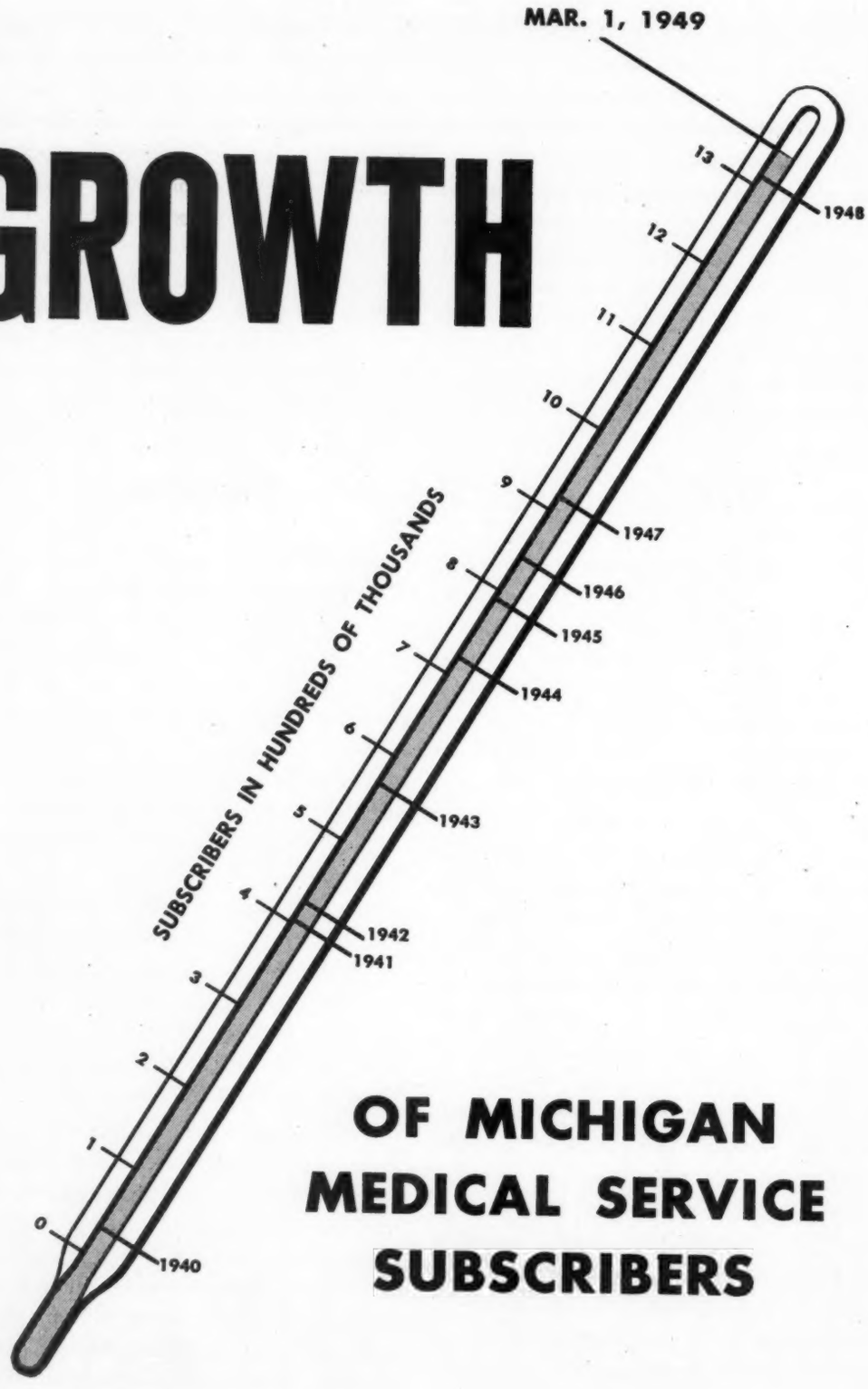
Blue Cross enrollment representatives and district managers conducted 3,600 resolicitations during the year in already-enrolled groups. These resolicitations resulted in more than 100,450 people being protected under the hospital plan, more than 142,100 under the surgical plan, and nearly 12,250 under the medical-surgical plan.

In October, the management-union board of trustees of the Kaiser-Frazier Company selected Blue Cross as the best protection for Kaiser-Frazer employes. As result of this selection, 100 per cent of all Kaiser-Frazier hourly employes were Blue Cross enrolled, the full cost of semi-private hospital-surgical protection being paid for by the trustees from a fund contributed by the company in accordance with its agreement with the union.

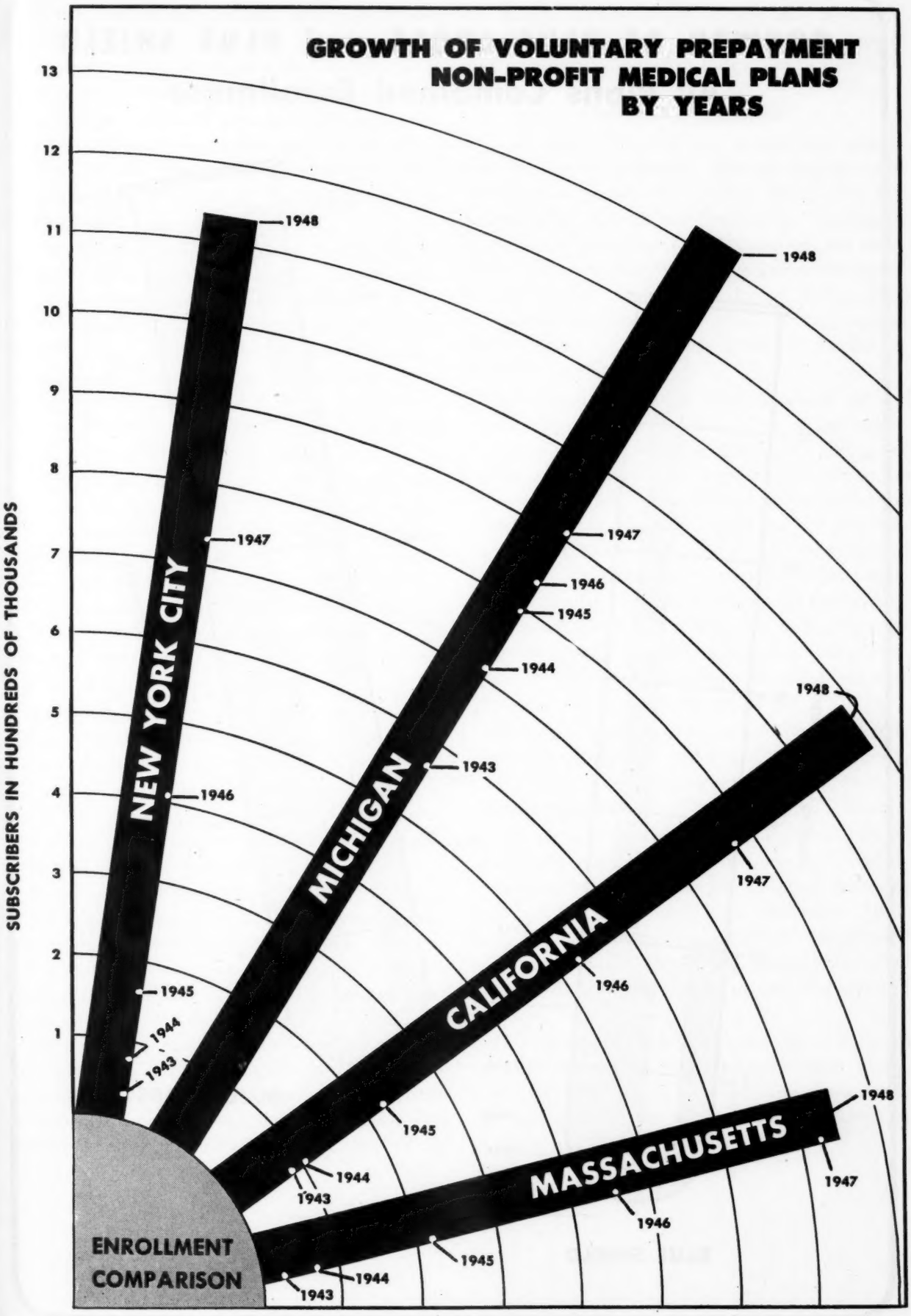
### Enrollment in Rural Areas

At the close of 1948, approximately 30,000 persons were enrolled in Blue Cross through 580 Michigan Farm Bureau groups. At the same time,

# GROWTH

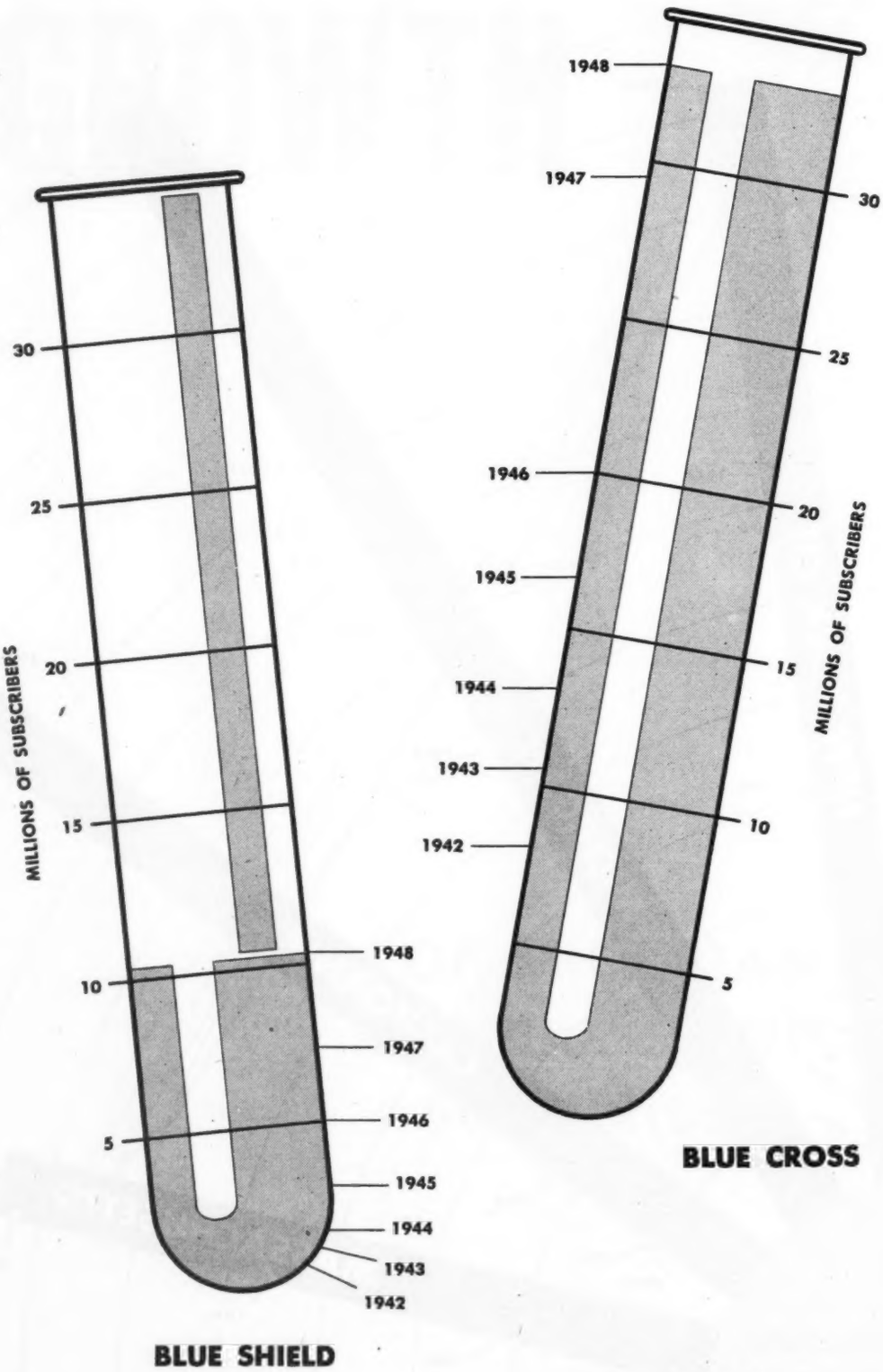



## OF MICHIGAN MEDICAL SERVICE SUBSCRIBERS


GROWTH OF VOLUNTARY PREPAYMENT
NON-PROFIT MEDICAL PLANS
BY YEARS
SUBSCRIBERS IN HUNDREDS OF THOUSANDS
13
12
11
10
9
8
7
6
5
4
3
2
1
NEW YORK CITY
1948
1947
1946
1945
1944
1943
MICHIGAN
1948
1947
1946
1945
1944
1943
CALIFORNIA
1948
1947
1946
1945
1944
1943
MASSACHUSETTS
1948
1947
1946
1945
1944
1943
ENROLLMENT
COMPARISON

# GROWTH OF BLUE CROSS and BLUE SHIELD

## All Plans Combined Enrollment



3,000 members of fifty Grange groups were also Blue Cross enrolled.

The rural phase of Blue Cross enrollment is handled on a group basis, largely through local Farm Bureau and local Grange organizations. A definite percentage of membership enrollment is required, and the number is established by a roster of membership provided by the group prior to its acceptance.

Although Blue Cross enrollment among Grange members leaves much to be desired, Grange members have become increasingly interested in the Blue Cross program. Blue Cross activities among Grange groups are now being organized on a "down-the-line" basis in a similar manner to the organization of Farm Bureau-Blue Cross activities, and the State Grange Deputy has undertaken the program as part of his work.

Payments to Blue Cross from the rural groups are on a collection system. Each organized county has a county-wide Blue Cross secretary through whom Blue Cross functions. Yearly training conferences are held for the various local Blue Cross secretaries in each county. Blue Cross district managers or rural enrollment representatives appear before the conferences, explain the program, and give assistance in setting up the records.

A total of 9,000 new Blue Cross members were added through 114 new Farm Bureau groups in 1948. This was a greater increase in enrollment among rural groups than in any previous year, and much time was devoted to orientation and education of these organizations in the matter of enrollment and servicing subscribers.

Numerous rural groups have added the surgical or the medical-surgical service to the hospital-only plan which previously protected them. The result is that now more than half the rural subscribers have full hospital and surgical service, and most of the new groups enrolling take all three services.

The newest procedure introduced among the rural groups is Blue Cross enrollment on a county-wide basis. Blue Cross membership has formerly been available only through the Farm Bureau Discussion Groups. As all Farm Bureau members do not belong to Discussion Groups, the procedure will give an opportunity for Blue Cross membership to a larger number of Farm Bureau members.

### Community Enrollment

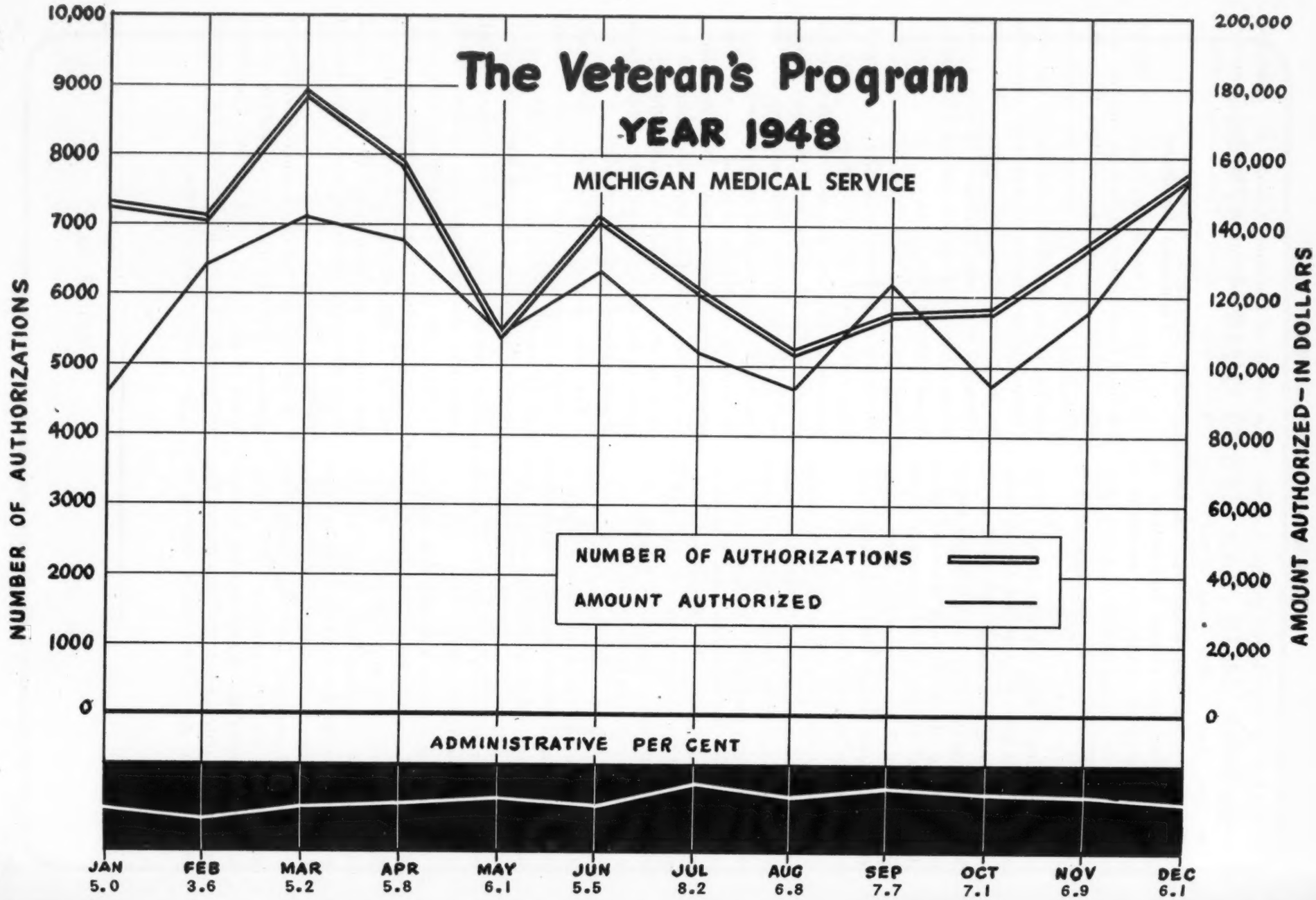
In its effort to reach the people not eligible for Blue Cross protection through employe and other already established groups, Blue Cross has increasingly stepped up community enrollment activities in towns and cities throughout the state. Community enrollment campaigns were conducted in twenty-one communities during 1948; eight campaigns have been held since January 1, and fifteen others are tentatively scheduled for the remainder of this year.

Two procedures have been followed in the community enrollment drives. One of the procedures calls for considerable time and expense for promotional activities; arrangements are made for dinner and luncheon meetings of civic and business leaders, doctors, hospital representatives and volunteers; all business places are canvassed; special literature is distributed to school children; store window displays, posters, table mats in restaurants, and motion picture films are used throughout the town; newspaper publicity is planned through cooperation with the local newspaper, and newspaper display advertisements are scheduled.

The other procedure is simple, requiring only publicity, advertising, radio spot announcements, and an enrollment headquarters in the town in which a Blue Cross participating hospital is located.

The average number of people enrolled through community enrollment activities has been slightly less than 5 per cent of the population of the towns in which the drives have been conducted. However, the campaigns have served a definite need and purpose in "discovering" prospective small groups which are overlooked in any other kind of canvass.

In addition, it is felt that community enrollment activities have done much to re-establish in the minds of local people that the Blue Cross Plans are operated by the doctors and the hospitals as their own voluntary programs.




MICHIGAN MEDICAL SERVICE

# Medical Service and Socialized Medicine

By Hon. Arthur H. Vandenberg
Senator from Michigan

THERE IS vast propaganda today for socialized medicine. I think it would destroy precious personal relationships in the American way of life, produce wholesale mediocrity in the skills which serve the sick, and saddle us with a new and appalling bureaucracy. But this does not require me to blind my eyes to the existence of a crushing and well-nigh universal sick problem in the lives of millions of our citizens. It is a problem that must be met. But we have a choice of methods. One is voluntary and therefore typically American. The other is involuntary and therefore typically bureaucratic. The latter is socialized medicine. The former is co-operative medicine. I expect the American people and the Republican Party to choose the former. I want my party to look at the great, humanitarian, co-operative effort of the Blue Cross, for example, which represents co-operation and not compulsion. It comes to finest fruition here in Michigan where one of four of our people already thus have cheaper and better protection than they would ever get from socialized medicine. Probably two out of four of our Michigan people are covered by this or other voluntary plans.—*Congressional Record,* February 14, 1949.

# Associated Medical Care Plans

THE ASSOCIATED Medical Care Plans, often referred to as "AMCP" or "Blue Shield," had their beginnings in the fall of 1942, when the few plans then in existence decided to get together in an attempt to help each other in problems of administration of voluntary nonprofit medical service plans.

A meeting held in Detroit resulted in the formation of the Council of Medical Service Plans of America in the spring of 1943. This was an informal association without charter, by-laws, or even any staff. Michigan Medical Service supplied much of the impetus toward the organization and its activity, as well as its chairman for the two years of its existence. Its activities consisted mostly of discussions held at times and places related to other medical group meetings.

The plans, originally eleven in number, had by 1945 grown to forty-three, and felt the need of a more formalized organization and a much expanded and co-ordinated activity in behalf of its member plans.

The present AMCP was organized in 1946 at meetings held at the AMA Headquarters in Chicago, and secured an Illinois nonprofit charter with a grant of $25,000 from the AMA to get it started. It is now sustained by dues from the member plans. With a membership of sixty-two plans, it now represents all qualified plans in the United States with the exception of four.

Its purposes are as set forth in its constitution:

"The objects of the corporation are to promote the establishment and operation of such nonprofit, voluntary medical care plans throughout the United States, its territories and possessions, and Canada as will adequately meet the health needs of the public and maintain the high quality of medical care rendered by the medical profession. Inherent in its objects is a recognition that state and local medical care plans should be autonomous in their operation so that the needs, facilities, resources and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the co-ordination through the medium of this corporation, of methods, coverages, operations and actuarial data."

Its affairs are directed by thirty commissioners, twelve plan executives, twelve plan trustees and six representatives of the Council on Medical Service of the AMA. The officers elected by the commission are:

President—Harold L. Schriner, M.D.
Vice President—R. L. Novy, M.D.
Secretary—O. B. Owens, M.D.
Treasurer—Jay C. Ketchum.

Responsible for the execution of its affairs in its Chicago headquarters are P. R. Hawley, M.D.,

as chief executive officer, and Mr. F. E. Smith, director.

AMCP has done much to encourage the development of new plans in state and local medical societies, assisted many plans with operating problems, particularly in the field of enrollment, statistics, accounting and plan relations with the public, the profession and with companion hospital service plans.

The problem of satisfactory enrollment methods for employes of national employers has been and is receiving a great deal of attention by the AMCP. There has been some difference of opinion in this matter. AMCP and the Council on Medical Service of the AMA have not always agreed on some proposals.

It has been pointed out that the AMCP is representative of the medical profession as is the Council on Medical Service or any other group within the AMA, inasmuch as the board of member plans are, in one way or another, chosen by the local or state societies, much as they select their delegates to the AMA, and in turn, the boards of the plans selected their representatives in AMCP and its commissioners.

Visitors and delegates to the annual meetings of the AMA in Atlantic City in June will be welcomed at the "Blue Shield" booth in the Exhibition Hall, where literature and information will be available.

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## THE MEANS

*(Continued from Page 740)*

At the Saint Louis Meeting of the American Medical Association, the House of Delegates restrained the Blue Shield Commission from forming certain national organizations for the better distribution of national sales problems. Just before the Blue Cross-Blue Shield conference which convened April 17, 1949, the American Medical Association, through its Council or Medical Service and its Board of Trustees, denied all responsibility for the Blue Shield Commission, except the right to approve or disapprove of its organizations, as well as other voluntary prepayment medical care plans.

Has the government used its power of prosecution to restrain official medical society support of the voluntary nonprofit health care plans, so that Oscar Ewing's pronouncement that they are inadequate to care for the American People may seem well founded?

## GENERAL PRACTICE SECTIONS IN HOSPITALS

The May 7 issue of the *Journal of the American Medical Association* contained the annual statistical report on hospital services in the United States for the year 1948. The data is collected annually by the Council on Medical Education and Hospitals of the American Medical Association. Included in this report was a summary of data on general practice sections in hospitals. The Council included in their annual census report for the year 1947 the following question: "In the organization of the medical staff, has the hospital established a general practice section?" Of the 4,539 general hospitals registered, 837 answered yes, 2,521 said no, and 1,181 did not reply to this question.

The majority of the hospitals that reported such sections were operated by churches or non-profit associations. Classified by bed capacity these hospitals were distributed as follows:

| | |
|---|---|
| 15 beds or less | 40 |
| 16- 25 beds | 101 |
| 26- 50 beds | 171 |
| 51-100 beds | 198 |
| 101-200 beds | 190 |
| 201-300 beds | 85 |
| Over 300 | 52 |
| Total Hospitals | 837 |

Although most of the hospitals with general practice sections in 1947 were medium sized, both very large and very small hospitals are included. It is apparent that size in no way precludes a general practice section.

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## S. 1679 CO-OPERATIVES

By Mr. Humphrey, of Minnesota, May 20:

Suggested amendment. To provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel.

Referred to the Committee on Labor and Public Welfare.

*Comment:* Provides the right for nonprofit associations and consumer *co-operatives to hire physicians* on a contract basis.

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## COWS SHOULD ALSO SEE DENTIST TWICE A YEAR

"See your dentist twice a year" is as good advice for Bossy as it is for Bossy's boss, declared Dr. L. M. Hurt, president of the American Veterinary Medical Association in Chicago. Cows are often benefited by dental attention, and return profit on the investment in better milk yield, he pointed out.

A typical and serious bovine dental ailment described by Dr. Hurt is known as "scissor-mouth." This is a condition wherein the lower jaw is considerably narrower than the upper, making it impossible for the poor animal to eat comfortably unless her teeth are dressed.—*Science News Letter,* May 21, 1949.

# MICHIGAN STATE MEDICAL SOCIETY

## The 84th Annual Session and Postgraduate Conference

O. O. Beck, M.D.
Birmingham
*Council Chairman*

E. F. Sladek, M.D.
Traverse City
*President*

John S. DeTar, M.D.
Milan
*Speaker*

**OFFICIAL CALL**

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 19, 20, 21, 22, 23, 1949. The provisions of the Constitution and By-Laws and the Official Program will govern the deliverations.

E. F. Sladek, M.D.
*President*
O. O. Beck, M.D.
*Council Chairman*
J. S. DeTar, M.D.
*Speaker*
R. H. Baker, M.D.
*Vice Speaker*

Attest:
L. Fernald Foster, M.D.
*Secretary*

L. Fernald Foster, M.D.
Bay City
*Secretary*

R. H. Baker, M.D.
Pontiac
*Vice Speaker*

### TWO-DAY SESSION OF HOUSE OF DELEGATES, SEPTEMBER 19-20, 1949

The 1949 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 19 at 10:00 a.m. The business of the House of Delegates will be transacted in the Pantlind Hotel, Grand Rapids.

The House also will meet Monday at 8:00 p.m. and on Tuesday, September 20 at 10:00 a.m. and 8:00 p.m.

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

**Seating of Delegates**

"A delegate once seated shall remain a Delegate throughout the entire session and for one year thereafter until the next Session of this House of Delegates, and his place shall not be taken by any other Delegate or Alternate, provided that in case of emergency the House of Delegates may seat a duly accredited Alternate from his component County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved.—MSMS By-Laws, Chapter 8, Section 6.

# Michigan State Medical Society

## Past Presidents 1866-1947

1866—*C. M. Stockwell, Port Huron
1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
1883—*A. F. Whelan, Hillsdale
1884—*Donald Maclean, Detroit
1885—*E. P. Christian, Wyandotte
1886—*Charles Shepard, Grand Rapids
1887—*T. A. McGraw, Detroit
1888—*S. S. French, Battle Creek
1889—*G. E. Frothingham, Detroit
1890—*L. W. Bliss, Saginaw
1891—*George E. Ranney, Lansing
1892—*Charles J. Lundy (died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
1894—*Henry O. Walker, Detroit
1895—*Victor C. Vaughan, Ann Arbor
1896—*Hugh McColl, Lapeer
1897—*Joseph B. Griswold, Grand Rapids
1898—*Ernest L. Shurly, Detroit
1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson
1903—*Wm. F. Breakey, Ann Arbor
1904—*B. D. Harison, Sault Ste. Marie
1905—*David Inglis, Detroit
1906—*Charles B. Stockwell, Port Huron
1907—*Hermon Ostrander, Kalamazoo
1908—*A. F. Lawbaugh, Calumet
1909—*J. H. Carstens, Detroit
1910—*C. B. Burr, Flint
1911—*D. Emmett Welsh, Grand Rapids
1912—*Wm. H. Sawyer, Hillsdale
1913—*Guy L. Kiefer, Detroit
1914—*Reuben Peterson, Ann Arbor
1915—*A. W. Hornbogen, Marquette
1916—*Andrew P. Biddle, Detroit
1917—*Andrew P. Biddle, Detroit
1918— Arthur M. Hume, Owosso
1919—*Charles H. Baker, Bay City
1920—*Angus McLean, Detroit
1921—*Wm. J. Kay, Lapeer
1922—*W. T. Dodge, Big Rapids
1923—*Guy L. Connor, Detroit
1924—*C. C. Clancy, Port Huron
1925—*Cyrenus G. Darling, Ann Arbor
1926— J. B. Jackson, Kalamazoo
1927— Herbert E. Randall, Flint
1928— Louis J. Hirschman, Detroit
1929— J. D. Brook, Grandville
1930—*Ray C. Stone, Battle Creek
1931—*Carl F. Moll, Flint
1932— J. Milton Robb, Detroit
1933—*George LeFevre, Muskegon
1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938— Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944— A. S. Brunk, Detroit
1945— R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids
1947—P. L. Ledwidge, Detroit

*Deceased.

# Michigan State Medical Society

## The 84th Annual Session and Postgraduate Conference and Cancer Control Day

**Pantlind Hotel-Civic Auditorium, Grand Rapids,**
**September 21-22-23-24, 1949**

### INFORMATION

- GRAND RAPIDS WILL BE HOST TO MSMS IN SEPTEMBER.

- **The Program** of the General Assembly at the 84th Annual Session and Postgraduate Conference and at the Cancer Control Day of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated postgraduate course in all phases of medicine and surgery for the busy practitioners of Michigan and neighboring states and the Province of Ontario, on September 21-22-23-24, 1949.

- **Registration,** Tuesday afternoon through Friday afternoon, September 20-23, Civic Auditorium. Advance registration—on Tuesday or early Wednesday morning—will save your time. Present your State Medical Society or Canadian Medical Association membership card to expedite registration.
  No registration fee for AMA and CMA members.
  Doctors of Medicine, who are not members of the American Medical Association or the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a $5 registration fee.
  *Register as soon as you arrive. Admission by badge only.*

- **Income Tax Deduction**—Expenses incurred in attending conventions of professional societies have consistently been held deductible in the income tax returns of doctors, both in the United States and Canada. Certificates of attendance available upon request to 2020 Olds Tower, Lansing 8, Michigan.

- **All Subjects** on the MSMS Annual Session and the Cancer Control Day Programs are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

- **Postgraduate Credits** given to every MSMS member who attends MSMS Annual Session.

- **Six General Assemblies** and one General Meeting—Thirteen Section Meetings—Twenty-one Discussion Conferences on September 21-22-23.

- **Public Meeting.** The General Meeting of Wednesday, September 21, 8:30 p.m.—Officers' Night—will be open to the public. Invite your patients and friends to hear an internationally famous personage present the Biddle Lecture, Ballroom, Pantlind Hotel.

- **Papers Will Begin and End on Time.** This scientific meeting will feature by-the-clock promptness and regularity.

- **MSMS House of Delegates** convenes Monday, September 19, at 10:00 a.m., Ballroom, Pantlind Hotel. It will hold two meetings on Monday, at 10:00 a.m. and at 8:00 p.m., also two meetings on Tuesday, September 20, at 10:00 a.m. and at 8:00 p.m.

- **One-hundred and Twenty-one Technical Exhibits and Eleven Scientific Exhibits** will contain much of interest and value. Intermissions to view the exhibits have been arranged.
  **Please Register at Every Booth.**

#### Cancer Control Day

- A special program on Cancer Control will be presented in the Ballroom of the Pantlind Hotel on Saturday morning, September 24. All doctors are urged to remain for these fine scientific presentations.

- J. Duane Miller, M.D., Grand Rapids, is General Chairman of the Grand Rapids Committee on Arrangements for the 1949 MSMS Annual Session and Postgraduate Conference.
  Press Relations Committee for the Scientific session: C. A. Payne, M.D., Chairman, G. T. Aitken, M.D., and P. W. Kniskern, M.D., all of Grand Rapids.

- **Transportation**—The C. & O. Streamliners from Detroit to Grand Rapids afford a convenient means of transportation to the MSMS Annual Session for hundreds of physicians in the central and southeastern parts of the State.

- **The Michigan Medical Assistants Conference** is scheduled for Thursday, September 22, with registration in the Pantlind Hotel beginning at 2:00 p.m.; cocktails at 6:00 p.m. and dinner at 7:00 p.m. The Medical Assistants group is composed of doctors' office secretaries and nurses.

- **Cabaret-Style Dance and Entertainment,** with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom, Pantlind Hotel, Thursday evening, September 22. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

- **Members of Michigan Medical Service** will meet in annual session Tuesday, September 20, Ballroom, Pantlind Hotel, at 2:00 p.m., following the MMS luncheon at 1:00 p.m. in the Schubert Room.

- **Information of Practical Value in Daily Practice** will be found at the Michigan State Medical Society Annual Session and at the Cancer Control Day.

**SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION**

# MICHIGAN STATE MEDICAL SOCIETY

## The 84th Annual Session and Postgraduate Conference

**Pantlind Hotel, Grand Rapids, September 19, 20, 21, 22, 23, 1949**

### HOUSE OF DELEGATES—ORDER OF BUSINESS*

**MONDAY, SEPTEMBER 19**

**Ballroom, Pantlind Hotel, Grand Rapids**

**10:00 a.m.—First Meeting**

1. **Call to order by Speaker.**
2. **Report of Committee on Credentials**
3. **Roll call**
4. **Appointment of Reference Committees**
   - (a) On Officers' Reports
   - (b) On Reports of The Council
   - (c) On Reports of Standing Committees
   - (d) On Reports of Special Committees
   - (e) On Constitution and By-Laws
   - (f) On Resolutions
   - (g) On Special Memberships
   - (h) Others
5. **Speaker's Address—J. S. DeTar, M.D., Milan**
6. **President's Address—E. F. Sladek, M.D., Traverse City**
7. **President-Elect's Address—W. E. Barstow, M.D., St. Louis**
8. **Annual Report of The Council—O. O. Beck, M.D., Birmingham, Chairman**
9. **Report of Delegates to American Medical Association—L. G. Christian, M.D., Lansing, Chairman**
10. **Report of Commision on Health Care—R. L. Pino, M.D., Detroit, Chairman**
11. **Resolutions****
12. **Reports of Standing Committees**
    - A. Committee on Postgraduate Medical Education
    - B. Preventive Medicine Committee:
      - (1) Rheumatic Fever Control Committee
      - (2) Cancer Control Committee
      - (3) Maternal Health Committee
      - (4) Venereal Disease Control Committee
      - (5) Tuberculosis Control Committee
      - (6) Industrial Health Committee
      - (7) Mental Hygiene Committee
      - (8) Child Welfare Committee
      - (9) Iodized Salt Committee
      - (10) Geriatrics Committee
        - (a) Sub-Committee on Diabetes Control
        - (b) Sub-Committee to Study Problem of Caring for Aged
      - (11) Committee on Infectious Diarrhea
    - C. Committee on Distribution of Medical Care
    - D. Committee on Public Relations (and subcommittees)
    - E. Committee on Ethics
    - F. Legislative Committee
13. **Reports of Special Committees**
    - A. Committee on State Veterans Affairs
    - B. State Interprofessional Committee
    - C. Beaumont Memorial Committee
    - D. Scientific Radio Committee
    - E. Advisory Committee to Woman's Auxiliary
    - F. Liaison Committee with State Medical Assistants Society
    - G. Advisory Committee to National Foundation for Infantile Paralysis
    - H. Committee on Increase of Medical Students Graduated from Michigan Medical Schools
    - I. Committee of Six to Study Basic Science Act and Medical Practice Act

**Reports of the Committees of the Council Are Included in the Annual Report of the Council**

**MONDAY, SEPTEMBER 19**

**Ballroom, Pantlind Hotel, Grand Rapids**

**8:00 p.m.—Second Meeting**

14. **Supplementary Report of Committee on Credentials**
15. **Roll call**
16. **Unfinished Business**

*See the Constitution Articles IV, VII and XII, and the By-Laws, Chapter 8 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 8, Section 10-m)

MONDAY, SEPTEMBER 19

17. New Business***
18. Reports of Reference Committees
    (a) On Officers Reports
    (b) On Reports of The Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships
    (h) Others

TUESDAY, SEPTEMBER 20

Ballroom, Pantlind Hotel, Grand Rapids

10:00 a.m.—Third Meeting

19. Supplementary Report of Committee on Credentials
20. Roll call
21. Unfinished Business
22. New Business
23. Supplementary Reports of Reference Committees
    (a) On Officers Reports
    (b) On Reports of The Council
    (c) On Reports of Standing Committees
    (d) On Reports of Special Committees
    (e) On Amendments to Constitution and By-Laws
    (f) On Resolutions
    (g) On Special Memberships
    (h) Others

TUESDAY, SEPTEMBER 20

Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fourth Meeting

24. Supplementary Report of Committee on Credentials
25. Roll call
26. Unfinished Business
27. Supplementary Report of The Council
28. Supplementary Reports of Reference Committees
29. Elections
    (a) Councilors
    14th District—D. W. Myers, M.D., Ann Arbor—Incumbent
    18th District—William Bromme, M.D., Detroit—Incumbent
    (b) Delegates to American Medical Association
    L. G. Christian, M.D., Lansing—Incumbent
    W. A. Hyland, M.D., Grand Rapids—Incumbent
    (c) Alternate Delegates to American Medical Association
    R. A. Johnson, M.D., Detroit—Incumbent
    H. H. Cummings, M.D., Ann Arbor—Incumbent
    (d) President-Elect
    (e) Speaker of House of Delegates
    (f) Vice Speaker of House of Delegates
30. Adjournment

## DELEGATES TO MSMS HOUSE OF DELEGATES, 1949

*Names of Alternates appear in Italics*

**Officers**
J. S. DeTar, M.D.
Milan, Speaker
R. H. Baker, M.D.
Peoples Bank Bldg., Pontiac, Vice Speaker
L. Fernald Foster, M.D.
919 Washington, Bay City, Secretary
P. L. Ledwidge, M.D.
1838 David Whitney Bldg., Detroit, Immediate Past President

**Allegan**
L. F. Brown, M.D., Otsego
*E. B. Johnson, M.D., Allegan*

**Alpena-Alcona-Presque Isle**
W. E. Nesbitt, M.D., Alpena
F. J. O'Donnell, M.D., Alpena

**Barry**
A. B. Gwinn, M.D., Hastings
*C. A. E. Lund, M.D., Middleville*

**Bay-Arenac-Iosco**
W. S. Stinson, M.D., 101 W. John, Bay City
A. D. Allen, M.D., 101 W. John, Bay City
*N. R. Moore, M.D., 5th and Madison Ave., Bay City*
*K. S. Haitinger, M.D., Auburn*

**Berrien**
D. W. Thorup, M.D., Benton Harbor
*D. M. Richmond, M.D., St. Joseph*

**Branch**
R. L. Wade, M.D., Coldwater
H. J. Meier, M.D., Coldwater

**Calhoun**
G. W. Slagle, M.D., 1206 Security Tower, Battle Creek
H. C. Hansen, M.D., 417 Post Bldg., Battle Creek
*P. P. Bonifer, M.D., 1008 Central Tower, Battle Creek*
*G. A. Zindler, M.D., 1506 Central Tower, Battle Creek*

**Cass**
S. L. Loupee, M.D., Dowagiac
*K. C. Pierce, M.D., Dowagiac*

**Chippewa-Mackinac**
B. T. Montgomery, M.D., Sault Ste. Marie
*D. C. Howe, M.D., Sault Ste. Marie*

**Clinton**
T. Y. Ho, M.D., St. Johns*
*G. E. Wahl, M.D., St. Johns*

**Delta-Schoolcraft**
O. S. Hult, M.D., Gladstone
*W. A. LeMire, M.D., Escanaba*

**Dickinson-Iron**
D. R. Smith, M.D., Iron Mountain
*L. E. Irvine, M.D., Iron River*

***All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 8, Section 10-m)

*Deceased

**Eaton**
G. C. Stucky, M.D., Charlotte
*Paul Engle, M.D., Olivet*

**Genesee**
C. W. Colwell, M.D., 706 Citizens Bank Bldg., Flint
C. K. Stroup, M.D., 2002 E. Court, Flint
F. W. Baske, M.D., 1217 Mott Foundation Bldg., Flint
J. E. Livesay, M.D., 619 Mott Foundation Bldg., Flint
*E. P. Vary, M.D., 608 National Bldg., Flint*
*L. M. Bogart, M.D., 1008 Genesee Bank Bldg., Flint*
*V. H. Morrissey, M.D., 101 Stockdale Drive, Flint*

**Gogebic**
H. A. Pinkerton, M.D., Ironwood
*D. C. Eisele, M.D., Ironwood*

**Grand Traverse-Leelanau-Benzie**
D. G. Pike, M.D., Traverse City
*H. L. Weitz, M.D., Traverse City*

**Gratiot-Isabella-Clare**
M. G. Becker, M.D., Edmore
*J. L. Rottschafer, M.D., Alma*

**Hillsdale**
L. W. Day, M.D., Jonesville
*O. G. McFarland, M.D., No. Adams*

**Houghton-Baraga-Keeweenaw**
T. P. Wickliffe, M.D., Calumet
*A. D. Aldrich, M.D., Houghton*

**Huron**
C. W. Oakes, M.D., Harbor Beach
*C. A. Scheurer, M.D., Pigeon*

**Ingham**
R. S. Breakey, M.D., 1211 Bank of Lansing Bldg., Lansing
L. G. Christian, M.D., 108 E. St. Joseph St., Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
*J. M. Wellman, M.D., 301 Seymour, Lansing*
*E. J. Robson, M.D., 728 Audubon Rd., E. Lansing*
*Milton Shaw, M.D., 320 Townsend, Lansing*

**Ionia-Montcalm**
W. L. Bird, M.D., Greenville
*C. M. Hansen, M.D., Stanton*

**Jackson**
C. S. Clarke, M.D., 605 Dwight Bldg., Jackson
J. D. Van Schoick, M.D., Hanover
*C. R. Dengler, M.D., 305 Carter Bldg., Jackson*
*J. B. Meads, M.D., 1406 City Bank Bldg., Jackson*

**Kalamazoo**
W. A. Scott, M.D., 705 Hanselman Bldg., Kalamazoo
R. W. Shook, M.D., 611 American National Bank Bldg., Kalamazoo
R. J. Armstrong, M.D., 605 Hanselman Bldg., Kalamazoo
*J. V. Fopeano, M.D., 1210 American National Bank Bldg., Kalamazoo*
*H. A. Machin, M.D., 420 John, Kalamazoo*
*N. L. DeWitt, M.D., 808 Hanselman Bldg., Kalamazoo*

**Kent**
Andrew Van Solkema, M.D., 953 E. Fulton, Grand Rapids
L. C. Carpenter, M.D., Metz Bldg., Grand Rapids
G. W. DeBoer, M.D., Medical Arts Bldg., Grand Rapids
A. V. Wenger, M.D., 302 Lorraine Bldg., Grand Rapids
W. B. Mitchell, M.D., 510 Medical Arts Bldg., Grand Rapids
J. W. Logie, M.D., Metz Bldg., Grand Rapids
*Torrance Reed, M.D., Ashton Bldg., Grand Rapids*
*W. R. Torgerson, M.D., Metz Bldg., Grand Rapids*
*S. L. Moleski, M.D., Medical Arts Bldg., Grand Rapids*
*C. E. Farber, M.D., Metz Bldg., Grand Rapids*
*L. O. Grant, M.D., Medical Arts Bldg., Grand Rapids*
*R. S. Van Bree, M.D., Loraine Bldg., Grand Rapids*

**Lapeer**
D. J. O'Brien, M.D., Lapeer
*H. B. Zemmer, M.D., Lapeer*

**Lenawee**
R. E. Dustin, M.D., Tecumseh
*C. H. Heffron, M.D., Adrian*

**Livingston**
H. G. Huntington, M.D., Howell
*R. W. Lieber, M.D., Howell*

**Luce**
F. R. Koss, M.D., Newberry
*M. A. Surrell, M.D., Newberry*

**Macomb**
D. B. Wiley, M.D., Utica
*R. F. Salot, M.D., 713 Monitor Leader Bldg., Mt. Clemens*

**Manistee**
E. B. Miller, M.D., Manistee
*J. F. Konopa, M.D., Manistee*

**Marquette-Alger**
N. J. McCann, M.D., Marquette
*Moses Cooperstock, M.D., Marquette*

**Mason**
E. B. Boldyreff, M.D., Custer
*R. R. Scott, M.D., Scottville*

**Mecosta-Osceola-Lake**
T. P. Treynor, M.D., Reed City
*Paul Ivkovich, M.D., Reed City*

**Medical Society of North Central Counties**
(Otsego - Montmorency - Crawford - Oscoda - Roscommon - Ogemaw - Gladwin - Kalkaska)
C. G. Clippert, M.D., 308 Michigan Ave., Brayling
*S. A. Stealy, M.D., Box 485, Grayling*

**Menominee**
J. R. Heidenreich, M.D., Daggett
*H. R. Brukardt, M.D., Menominee*

**Midland**
R. S. Ballmer, M.D., Midland
*Charles MacCallum, M.D., Midland*

**Monroe**
T. A. McDonald, M.D., 7 E. Front, Monroe
*J. P. Flanders, M.D., 31 Washington, Monroe*

**Muskegon**
R. D. Risk, M.D., Muskegon
T. J. Kane, M.D., 179 Strong Ave., Muskegon
*Louis LeFevre, M.D., 289 W. Wester, Muskegon*
*D. R. Boyd, M.D., 1735 Peck, Muskegon*

**Newaygo**
B. L. Masters, M.D., Fremont
*T. R. Deur, M.D., Grant*

**Northern Michigan**
(Antrim-Charlevoix-Emmet-Cheboygan)
J. R. Rodger, M.D., Bellaire
*L. E. Grate, M.D., Charlevoix*

**Oakland**
P. E. Sutton, M.D., 617 Washington Square Bldg., Royal Oak
H. A. Furlong, M.D., 932 Riker Bldg., Pontiac
C. R. Gatley, M.D., Route 3, Pontiac
R. H. Baker, M.D., 1110 Peoples Bank Bldg., Pontiac
*J. D. Green, M.D., 311 Wabeek Bank Bldg., Birmingham*
*F. J. Kemp, M.D., 1115 Peoples State Bank Bldg., Pontiac*
*O. R. MacKenzie, M.D., 128 Common, Walled Lake*
*J. M. Markley, M.D., 1026 Riker Bldg., Pontiac*

**Oceana**
W. H. Heard, M.D., Pentwater
*W. G. Robinson, M.D., Hart*

**Ontonagon**
W. F. Strong, M.D., Ontonagon
*S. H. Rubinfeld, M.D., Ontonagon*

**Ottawa**
D. C. Bloemendaal, M.D., Zeeland
*K. N. Wells, M.D., Spring Lake*

**Saginaw**
C. E. Toshach, M.D., 330 So. Jefferson Ave., Saginaw
H. D. Helmkamp, M.D., 2nd Nat. Bk. Bldg., Saginaw
*H. M. Bishop, M.D., 515 So. Jefferson, Saginaw*
*W. K. Slack, M.D., 308 Eddy Bldg., Saginaw*

**Sanilac**
R. K. Hart, M.D., Croswell
*Frank Ruhl, M.D., Croswell*

**Shiawassee**
C. L. Weston, M.D., Owosso
*G. W. Bennett, M.D., Owosso*

**St. Clair**
George Waters, M.D., Port Huron
*W. H. Boughner, M.D., Algonac*

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*S. A. Fiegel, M.D., Sturgis*

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L. L. Savage, M.D., Caro
*R. O. Flett, M.D., Millington*

**Van Buren**
W. R. Young, M.D., Lawton
*Edwin Terwilliger, M.D., South Haven*

**Washtenaw**
O. K. Engelke, M.D., Washtenaw County Health Department, Ann Arbor
R. W. Teed, M.D., 215 S. Main, Ann Arbor
P. S. Barker, M.D., University Hospital, Ann Arbor
B. M. Harris, M.D., Ypsilanti
H. H. Riecker, M.D., St. Joseph's Mercy Hospital, Ann Arbor
*R. I. Seime, M.D., 302 W. Cross, Ypsilanti*
*H. A. Miller, M.D., 201 S. Ann Arbor Street, Saline*
*A. M. Waldron, M.D., 9 Geddes Height, Ann Arbor*

**Wayne**
J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
W. W. Babcock, M.D., 868 Fisher Bldg., Detroit
C. J. Barone, M.D., 13535 Woodward Ave., Highland Park
Arch Walls, M.D., 12065 Wyoming, Detroit
R. L. Novy, M.D., 858 Fisher Bldg., Detroit
Douglas Donald, M.D., 7815 E. Jefferson, Detroit
C. L. Candler, M.D., 2006 David Broderick Tower, Detroit
F. A. Weiser, M.D., Grace Hospital, Detroit
G. C. Penberthy, M.D., 1515 David Whitney Bldg., Detroit
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit
E. D. Spalding, M.D., 320 Professional Bldg., Detroit
T. K. Gruber, M.D., Wayne County General Hospital, Eloise
E. C. Texter, M.D., 7457 Gratiot Ave., Detroit
C. I. Owen, M.D., Grace Hospital, Detroit
W. B. Cooksey, M.D., 62 W. Kirby, Detroit
B. H. Douglas, M.D., 334 Bates, Detroit
E. G. Krieg, M.D., 1842 David Whitney Bldg., Detroit
D. C. Beaver, M.D., 432 E. Hancock, Detroit
W. J. Cassidy, M.D., 1737 David Whitney Bldg., Detroit
W. S. Reveno, M.D., 968 Fisher Bldg., Detroit
C. D. Benson, M.D., 1515 David Whitney Bldg., Detroit
M. A. Darling, M.D., 673 Fisher Bldg., Detroit
G. T. McKean, M.D., 1515 David Whitney Bldg., Detroit
R. H. Pino, M.D., 208 David Whitney Bldg., Detroit
H. F. Dibble, M.D., 1317 David Whitney Bldg., Detroit
C. K. Hasley, M.D., 1429 David Whitney Bldg., Detroit
H. J. Kullman, M.D., Veterans Administration Hospital, Dearborn
D. H. Kaump, M.D., Providence Hospital, Detroit
J. A. Kasper, M.D., Herman Keifer Hospital, Detroit
H. B. Fenech, M.D., 10 Peterboro, Detroit
L. W. Hull, M.D., 1701 David Whitney Bldg., Detroit
E. G. Bovill, M.D., 9203 Grand River, Detroit
L. T. Henderson, M.D., 13038 E. Jefferson, Detroit
J. E. Lofstrom, M.D., 410 Kales Bldg., Detroit
R. A. Johnson, M.D., 7815 E. Jefferson, Detroit
L. J. Morand, M.D., 641 David Whitney Bldg., Detroit
R. V. Walker, M.D., 1255 David Whitney Bldg., Detroit
L. J. Bailey, M.D., 10 Peterboro, Detroit
E. H. Fenton, M.D., 15125 Grand River, Detroit
R. L. Schneck, M.D., 641 David Whitney Bldg., Detroit
L. S. Fallis, M.D., Henry Ford Hospital, Detroit
E. H. Lauppe, M.D., 1650 David Whitney Bldg., Detroit
R. F. Fenton, M.D., 15125 Grand River, Detroit
*W. L. Brosius, M.D., 1151 Taylor Ave., Detroit*
*J. E. Croushore, M.D., 573 Fisher Bldg., Detroit*
*E. D. King, M.D., 5455 W. Vernor, Detroit*
*D. I. Sugar, M.D., 17 Brady, Detroit*
*J. A. Witter, M.D., 344 Glendale, Detroit*
*W. S. Carpenter, M.D., 1317 David Whitney Bldg., Detroit*
*L. R. Leader, M.D., 1139 David Whitney Bldg., Detroit*
*H. L. Morris, M.D., 1069 Fisher Bldg., Detroit*
*J. R. Adams, M.D., 14741 Michigan, Dearborn*
*K. M. McColl, M.D., 18520 E. Warren, Detroit*
*A. V. Forrester, M.D., 18950 Woodward, Detroit*
*Sidney Adler, M.D., 872 Fisher Bldg., Detroit*
*E. C. Long, M.D., 2626 Rochester, Detroit*
*W. P. Chester, M.D., 5057 Woodward Ave., Detroit*
*S. M. Gillespie, M.D., 1011 Haigh, Dearborn*
*H. F. Raynor, M.D., 1340 Maccabees Bldg., Detroit*
*Mary M. Frazer, M.D., 812 Kales Bldg., Detroit*
*J. K. Bell, M.D., 1654 National Bank Bldg., Detroit*
*E. F. Dittmer, M.D., 14320 E. Jefferson, Detroit*
*T. T. Callaghan, M.D., 10 Peterboro, Detroit*
*V. N. Butler, M.D., 28 W. Adams, Detroit*
*C. S. Ratigan, M.D., 22276 Garrison, Dearborn*
*A. E. Schiller, M.D., 2010 David Broderick Tower, Detroit*
*E. J. Hammer, M.D., 16616 Mack, Detroit*
*H. M. Nelson, M.D., 1067 Fisher Bldg., Detroit*
*W. J. Yott, M.D., 15744 Harper, Detroit*
*W. G. Bernard, M.D., 13002 E. Jefferson, Detroit*
*L. J. Gravelle, M.D., 1101 David Whitney Bldg., Detroit*
*C. A. Coates, M.D., 21576 Michigan, Dearborn*
*C. R. DeFever, M.D., 15124 Kercheval, Detroit*
*C. R. Lam, M.D., Henry Ford Hospital, Detroit*
*P. J. Waltz, M.D., 16127 Woodward, Highland Park*
*L. J. Gariepy, M.D., 16401 Grand River, Detroit*
*S. A. Zukowski, M.D., 6626 Van Dyke, Detroit*
*H. A. Ott, M.D., 706 Maccabees Bldg., Detroit*
*E. M. Vardon, M.D., 12897 Woodward, Detroit*
*W. A. Chipman, M.D., 14920 Grand River, Detroit*
*E. D. Maire, M.D., 15224 E. Jefferson, Detroit*
*J. R. Brown, M.D., 702 Maccabees Bldg., Detroit*
*E. L. Cooper, M.D., 414 David Whitney Bldg., Detroit*
*M. H. Miller, M.D., 8120 W. McNichols, Detroit*
*G. L. Coan, M.D., 114 Maple, Wyandotte*
*J. M. LaBerge, M.D., 114 Maple, Wyandotte*

**Wexford-Missaukee-Kalkaska**
M. R. Murphy, M.D., Cadillac
*R. V. Daugharty, M.D., Cadillac*

# REFERENCE COMMITTEES, CREDENTIALS COMMITTEE, AND PRESS RELATIONS COMMITTEE

## HOUSE OF DELEGATES, 1949

*(All meetings of Reference Committees will be held in the Pantlind Hotel, Grand Rapids)*

### Credentials Committee

L. J. Bailey, M.D., Detroit, Chairman and Sergeant-at-Arms
A. B. Gwinn, M.D., Hastings
W. S. Stinson, M.D., Bay City

* * *

## REFERENCE COMMITTEES

### Officers' Reports
### Room 322

W. S. Reveno, M.D., Detroit, *Chairman*
C. W. Oakes, M.D., Harbor Beach
R. J. Armstrong, M.D., Kalamazoo
H. W. Wiley, M.D., Lansing
N. J. McCann, M.D., Marquette
J. J. Lightbody, M.D., Detroit
C. D. Benson, M.D., Detroit

### Reports of The Council
### Parlor A

P. E. Sutton, M.D., Royal Oak, *Chairman*
C. L. Weston, M.D., Owosso
D. C. Bloemendaal, M.D., Zeeland
C. J. Barone, M.D., Detroit
W. W. Babcock, M.D., Detroit
D. R. Smith, M.D., Iron Mountain
L. J. Morand, M.D., Detroit

### Reports of Standing Committees
### Room 324

F. A. Weiser, M.D., Detroit, *Chairman*
J. D. Van Schoick, M.D., Hanover
J. R. Heidenreich, M.D., Daggett
R. S. Ballmer, M.D., Midland
L. L. Savage, M.D., Caro
E. G. Bovill, M.D., Detroit
E. H. Fenton, M.D., Detroit

### Reports of Special Committees
### Room 327

G. T. McKean, M.D., Detroit, *Chairman*
W. B. Mitchell, M.D., Grand Rapids
G. C. Stucky, M.D., Charlotte
E. C. Texter, M.D., Detroit
J. A. Kasper, M.D., Detroit
E. G. Krieg, M.D., Detroit
S. L. Loupee, M.D., Dowagiac

### Constitution and By-Laws
### Room 328

T. K. Gruber, M.D., Eloise, *Chairman*
T. J. Kane, M.D., Muskegon
R. A. Springer, M.D., Centerville
L. C. Carpenter, M.D., Grand Rapids
C. K. Hasley, M.D., Detroit

### Resolutions
### Parlor B

B. M. Harris, M.D., Ypsilanti, *Chairman*
W. J. Cassidy, M.D., Detroit
C. G. Clippert, M.D., Grayling
R. S. Breakey, M.D., Lansing
D. W. Thorup, M.D., Benton Harbor
R. H. Pino, M.D., Detroit
W. F. Strong, M.D., Ontonagon

### Rules and Order of Business
### Parlor A

E. D. Spalding, M.D., Detroit, *Chairman*
W. R. Young, M.D., Lawton
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* * *

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# Michigan's Department of Health

**Albert E. Heustis, M.D., Commissioner**

## TO ARRANGE FOR CONTINUING IMMUNIZATION

To provide maximum protection of Michigan children against preventable disease, May was designated as Immunization and Child Health Month in the state, and co-ordinated effort of practicing physicians, health agencies, schools, parents and community groups was sought to set up local plans for continuing immunization of all children.

Governor G. Mennen Williams, in proclaiming the month, pointed out the importance of child health to the future of the state and called upon all parents to assure their own children's protection and to co-operate in assuring protection for all children in the community.

To help to secure the protection, the Michigan Department of Health developed and released the following basic immunization policies:

1. It is the responsibility of the local health department to see that children are immunized against preventable disease.
2. It is essential that this protection be given each child before his first birthday. The immunization of children under one year of age is a life-saving procedure.
3. It is also essential that the immunization of each child be boosted before the age of the three years, and again at five years, before entering school.
4. The private physician should be utilized to the fullest extent in both the primary protection and in the three-year booster treatments. This youngest age group does not adapt itself well to mass clinic procedures, and bringing these youngsters together is hazardous from the standpoint of contagion.
5. The preschool reimmunization of children (and the reimmunization or immunization of school children) is a joint responsibility of school and parent groups, health departments and private physicians.
6. Immunization should be available for those children whose parents are unable or unwilling to pay for it.
7. State and local health departments must carry on vigorous educational campaigns regarding immunization.
8. The local health department should take the responsibility for co-ordinating and developing a written plan for long-range continuing immunization against whooping cough, diphtheria, smallpox and tetanus for all the children within its jurisdiction, working co-operatively with the practicing physicians, the schools, parents and all local groups interested in child health.
9. The services of the staff of the Michigan Department of Health should be available wherever needed in education, in helping with the planning of the long-range program, or in arbitrating, when local groups cannot reach agreement upon a plan.

To carry out its share in the responsibilities, the Department devoted a series of six weekly radio broadcasts to subjects related to child and immunization. Dr. Albert E. Heustis spoke on the need for immunization; Dr. Goldie Corneliuson attempted to disprove certain "old wives tales" which hamper child health and immunization programs; Dr. Pearl Kendrick told of the need of whooping cough vaccination and other facts regarding the disease; Dr. Otto Engelke, director of the Washtenaw County Health Department, and Dr. F. S. Leeder discussed diphtheria prevention; Georgia Hood told of the importance of summer followup of school health services; and Mrs. Alice Smith talked on feeding the school child. Copies of these scripts were loaned for use elsewhere.

The Department sent out weekly news stories on immunization and child health to newspapers, press associations and radio stations of the state. It prepared and sent to each radio station of the state a series of "station breaks" or "spot" announcements for use during the month. It furnished material to the Michigan Congress of Parents and Teachers, the Department of Public Instruction, the Michigan Education Association JOURNAL and a group of educators from the State Grange for their use.

Each item of mail which left the Michigan Department of Health during May bore the meter stamp "Immunization Protects Your Child." The Department sends out approximately 50,000 items of metered mail on an average month. The figure for May was undoubtedly higher.

The Department revised "My Record of Immunization," and copies of the reviewed folder are sent with each notification of birth registration. Additional copies were made available to practicing physicians and parents through the local health departments.

The Department prepared and distributed to physicians of the state a fourth revision of "Recommended Immunization and Diagnostic Procedures for Physicians." It also prepared a brief outline of suggested "Immunization Schedules, 1949" and a small placard "A Message to Parents" signed by the Commissioner for use in the practicing physicians' offices. These items for physicians plus the Immunization Record form were sent to several thousands of practicing physicians along with an Immunization Month letter. Demands for additional copies from health departments, physicians, and individuals literally swamped the Department.

The laboratories of the Department held ample stocks of immunizing agents in readiness to meet the increasing demands brought about by the special emphasis of the month. Services of staff members of the Department were made available to any community of

*(Continued on Page 770)*

## ARRANGE FOR CONTINUING IMMUNIZATION

*(Continued from Page 768)*

the state for education, and for assistance in developing long-range immunization programs.

The Department sent one special and one regular issue of its Interdepartmental Circular, carrying information on the Immunization and Child Health Month purposes and activities and making suggestions for the local planning.

Local health departments were urged to plan and coordinate such activities in each community as might result in the development of a written and accepted long-range program of continuing immunization for all children in their jurisdictions.

They were advised to meet with the local medical society, plan co-operative programs with schools, parents, community groups and agencies, and to arrange for immunization month material to be read in all community meetings during May.

They were also urged to use every means possible to persuade parents of the importance of immunization in infancy and booster shots by age three and at age five. It was suggested that they have the mayor proclaim Immunization and Child Health Month; urge all organizations to devote programs to the subject during the Month; stimulate interest of newspapers and radio and provide them with copy; have each minister talk on immunization from his pulpit; send immunization materials by letters to interested groups and individuals; use immunization displays wherever possible, and use a rubber stamp on mail, advising immunization.

These activities and the co-operation of other agencies, it is hoped, will result in continued long-range immunization programs for the protection of children in many sections of the state.

## BLOOD PLASMA EMERGENCY

The American Red Cross has made its last shipment of free dried blood plasma from wartime surpluses to 200 hospitals in Michigan. In many cases this supply will be totally exhausted this month. Many hospitals in this state are facing a serious emergency.

This Department is mustering every resource to expand its plasma procurement program in order to be able to supply sufficient free plasma to meet the state's needs.

Whether free plasma is available in a local community now depends entirely on the co-operation of the community in the state free blood plasma procurement program. Unless there are sufficient donors in each community, the hospital patients in that community will have to purchase supplies from private or commercial sources. This also applies to gamma globulin for modification of measles and other fractions of blood. For some types of injury or illness the cost of plasma and fractions runs into thousands of dollars. Delay in finding donors with the right type of blood can prove fatal. The blood given in a local community is fractionated in the Lansing Laboratories and returned for use, without charge, in the donating community.

*(Continued on Page 772)*

## BLOOD PLASMA EMERGENCY

*(Continued from Page 770)*

Local Red Cross chapters throughout the state are now mobilizing donors for clinics which the Department will operate. Local medical societies are co-operating.

The co-operation of local medical societies in publicizing the seriousness of the emergency, and in recruitment of donors, is urged at this time.

## DANGER IN SHOE-FITTING MACHINES

Indiscriminate and too frequent use of fluoroscopic shoe-fitting machines is dangerous to health of the shoe store employe and customer alike, the Michigan Department of Health has warned the public.

No individual should have fluoroscopic fittings more than twelve times a year, and each exposure should be limited to five seconds.

Fluoroscopic shoe-fitting machines should not be used as playthings, nor be operated by customers.

The Division of Industrial Health has investigated the potential hazards of fluoroscopic shoe-fitting machines and is now in the process of checking all the machines in use in the state.

Some machines, particularly of the older type which are not properly shielded emit or leak stray radiation into the area around them. This is particularly hazardous for employes who are exposed to the rays eight hours a day. Older machines are the most apt to be faulty. The Division hopes to check these machines first. To protect the health of their employes and their customers, owners of these older machines should immediately request the services of the Division of Industrial Health.

## INCIDENCE OF CERTAIN REPORTABLE DISEASES

| *Disease* | *April 1949* | *April 1948* |
|---|---|---|
| Diphtheria | 4 | 4 |
| Gonorrhea | 636 | 658 |
| Lobar pneumonia | 141 | 80 |
| Measles | 3,019 | 6,484 |
| Meningococcic meningitis | 14 | 14 |
| Pertussis | 112 | 285 |
| Poliomyelitis | 3 | 6 |
| Rheumatic fever | 89 | 73 |
| Scarlet fever | 1,473 | 604 |
| Syphilis | 710 | 973 |
| Tuberculosis | 400 | 628 |
| Typhoid fever | 3 | 4 |
| Undulant fever | 26 | 23 |
| Smallpox | 0 | 0 |

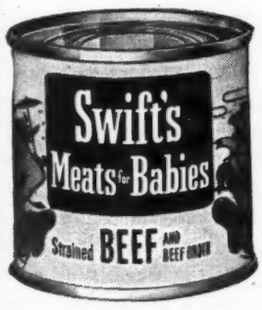
## VENEREAL DISEASE IN HIGH SCHOOL

An article discussing the incidence of venereal disease among Michigan high school pupils, written by Dr. John A. Cowan, director of the Division of Tuberculosis and Venereal Disease Control, appears in the April issue of the *Journal of the Michigan Education Association*. The article is entitled "VD Invades the Classroom."

*(Continued on Page 776)*

# Soft-diet patients down in the mouth?

## Perk up appetites with Swift's Strained Meats!




**6 varieties:**
**Beef, lamb, pork, veal, liver, heart**

Simply putting soft foods on a tray is no assurance that patients will put them away. That's why so many physicians today are recommending Swift's Strained Meats—flavorful, real meats they're sure patients will eat! Prepared specially, soft and smooth, Swift's Strained Meats are so good they tempt even the most apathetic appetites!

Nutritionally, Swift's Strained Meats are an excellent base for a high-protein, low-residue diet. They're highly digestible—easy to eat. Rich in biologically valuable proteins, they make available simultaneously all known essential amino acids—for optimum protein synthesis. Further, Swift's Strained Meats supply hemapoeitic iron and goodly amounts of natural B vitamins. Let protein-rich Swift's Strained Meats put palatability in menus for your soft-diet patients!

To vary patient's menus, six different Swift's Strained Meats: beef, lamb, pork, veal, liver, heart. Convenient—ready to heat and serve!

*The makers of Swift's Strained Meats invite you to send for the new physicians' handbook of protein feeding, written by a doctor, "The Importance of Protein Foods in Health and Disease." Send to:*

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**Chicago 9, Illinois**

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

*All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.*


For patients who can take foods of less fine consistency—Swift's Diced Meats offer tender morsels of nutritious meats with tempting flavors patients appreciate.

# Communications

E. F. Sladek, M.D., President,
Michigan State Medical Society,
Lansing 8, Michigan.

Dear Dr. Sladek:

Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, has written me that the Society has made me the recipient of an Award. This has just been forwarded to me by my son, Dr. Frederick Coller.

I am very proud to receive it and appreciate deeply the honor shown me. Will you, as president, please express to the members of the Medical Society my sincere appreciation and thank them for showing me this distinction?

Thank you for your personal congratulations and kind wishes.

With kindest regards, I am,

Sincerely yours,
GRANVILLE J. COLLER, M.D.

May 11, 1948

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Wilfrid Haughey, M.D.
Editor, MICHIGAN STATE MEDICAL SOCIETY JOURNAL
Battle Creek, Michigan

Dear Doctor Haughey:

In September, 1948, the House of Delegates of the Michigan State Medical Society introduced a resolution relative to the creation of a medical library service. This resolution appears in the MICHIGAN STATE MEDICAL JOURNAL for November, 1948, page 1270. It would appear that some of the doctors in the state are not familiar with the present arrangement for loan of books, periodicals, and journals. I am, therefore, sending this letter to you in the hope that the following information may become familiar to all the doctors through publication in the JOURNAL of the Society.

The library of the University of Michigan through an inter-library loan service has available for use by any doctor in the state over 80,000 books and 800 journals and periodicals. Five separate books, periodicals or journal-volumes may be obtained at any one time. Additional loans may be made as the originals are returned. Requests are filled and sent by parcel post or express within twenty-four hours of receipt of inquiry. The expense of transportation is assumed by the lender.

To procure references it is suggested that the physician contact the home library, which in turn will obtain the books through inter-library loan service. If, however, a general library is not available, requests may be made by letter or telephone to the University of Michigan Medical Library, Ann Arbor, Michigan. Duplicate copies of current medical journals are available, and if the demand justifies, an attempt will be made to obtain

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*(Continued from Page 774)*

additional copies, thus assuring reasonable fulfillment of any journal request. During the past year about 300 doctors outside of Ann Arbor obtained 1,100 volumes through this service.

The Department of Postgraduate Medicine, through its office in room 2040, University Hospital, Ann Arbor, is available for any additional help in obtaining reference material.

Sincerely yours,
H. H. CUMMINGS, M.D.

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## MICHIGAN'S DEPARTMENT OF HEALTH

*(Continued from Page 772)*

### NEW MANUAL ON PREMATURES

A copy of the new book, "Premature Infants," written by Ethel C. Dunham, M.D., international authority in the field of prematurity, has been sent to each local health department in the state. Physicians who wish to inspect the book may see it in the department. Physicians may buy copies from the Superintendent of Documents, United States Government Printing Office, Washington, D. C., for $1.25 each.

### TUBERCULOSIS DEATH RATE TO DROP

Provisional figures indicate a drop in the Michigan tuberculosis death rate for 1948. There were 1,643 deaths from all forms of tuberculosis in 1947. This represents a rate of 27.07 per 100,000 population. Figures for 1948 show 1,560 deaths from tuberculosis, or a rate of 25.18.

### SOCIAL HYGIENE FILM AVAILABLE FOR SUMMER

"The Miracle of Living," a thirty-nine-minute, 16 mm., sound, army training film on venereal disease is available from the Film Loan Library of the Department until September 1. The film, dramatic entertainment suitable for showing to the general public, emphasizes the need to protect the family from venereal disease and shows the effects of syphilis and gonorrhea on young people and its result in broken homes.

### STAFF MEMBERS ELECTED

John Hepler, director of the Division of Engineering, has been named secretary of the Michigan Engineering Society.

Dr. K. E. Markuson, director of the Division of Industrial Health, has been named chairman of the American Conference of Governmental Industrial Hygienists and president of the Michigan Association of Industrial Physicians and Surgeons.

# . . . . . NEWS MEDICAL

*Michigan Authors.*—Darrell A. Campbell, M.D., Eloise, Michigan, published a paper in *Annals of Surgery,* March, 1949: "Resection of the Sternum for Metastic Carcinoma."

Frand C. Lutman, M.D., Philadelphia, Pennsylvania, and James V. Neel, Ph.D., Ann Arbor, Michigan, published a paper in *Archives of Ophthalmology,* March, 1949: "Inheritance of Arachnodactyly, Ectopia Lentis and Other Congenital Anomalies (Marfan's Syndrome) in the E. Family."

W. J. Nungester, M.D., R. L. Thirlby, M.D., and A. B. Vial, M.D., Ann Arbor, Michigan, published a paper in *Surgery, Gynecology and Obstetrics,* May, 1949: "Evaluation of Hexachlorophene and Detergents as Substitutes for the Surgical Scrub; a Biological Technique."

Darrell A. Campbell, M.D., Eloise, Michigan, and Bert Bradford, Jr., M.D., Charleston, W.Va., published a paper, "Actinomycosis of the Thorax and Abdomen," August, 1948, in *Archives of Surgery.*

* * *

Henry K. Fansom, M.D., Ann Arbor, Michigan, was one of the guest speakers of the Kansas Medical Society in Topeka, Kansas, May 10, 1949—subject: "Inflammatory Lesions of the Intestines."

* * *

*Saginaw Valley Academy.*—Thirty eye, ear, nose and throat doctors attended a dinner meeting of the Saginaw Valley Academy of Ophthalmology and Otolaryngology at the Elk's Club, April 12, 1949.

Dr. J. Conrad Gemeroy, Detroit, gave an illustrated talk on external eye diseases. Dr. Harold H. Hiscock, president of the Genesee County Medical Society, with Dr. Rudolph W. Streat, welcomed members to their first meeting in Flint.

* * *

*Certificates Ready for Former Flight Surgeons.*—Certificates are now ready for mailing to former medical officers who served during the war with the designation as flight surgeons.

The certificates, which are suitable for framing, indicate that the officer concerned was graduated from the Aviation Medical Examiner's Course given at the U. S. Air Force School of Aviation Medicine, Randolph Air Force Base, Texas. Those who are eligible to receive the certificates may secure them by writing direct to the Air Surgeon, Headquarters, U. S. Air Force, Washington 25, D. C. Officers now on active duty are not eligible to receive the certificates.

*International Academy of Proctology.*—The first meeting of the newly formed International Academy of Proctology was held at the Marlborough-Blenheim in Atlantic City, N. J., on Friday, June 10, 1949.

The scientific portion of the program consisted of the presentation of papers and motion picture films of interest to all physicians as well as to those specializing in proctology.

* * *

*Air Surgeon Initiates General Practice Branch.*—Air Surgeon Major General Malcolm C. Grow has announced the initiation of a General Practice Branch in the Air Surgeon's office, to be charged with the development of training opportunities and careers for general practitioners serving at USAF installations.

According to current Air Force organization, approximately 70 per cent of physicians serving with USAF units are general practitioners. Of the remainder, 5 per cent are staff and administrative personnel and 25 per cent are specialists.

Initiation of the new General Practice Branch was considered imperative by General Grow who characterized the general practitioner as "the backbone of the Air Force medical service."

Under the new program the general practitioner will be enabled to enter into a proposed residency program to be operated in the General Hospital setup. The residency program will offer the general practitioner access to latest technical developments in medical and surgical specialties. Special emphasis will be placed on internal medicine, surgical practices, pediatrics and obstetrics.

The new General Practice Branch will work cooperatively with the Surgeon General's career program for medical officers.

* * *

*New York Plan Threatens to Top Michigan as Largest Blue Shield Plan.*—Reporting a net gain of better than 165,000 members during the first quarter of 1949, United Medical Service, New York, threatens to replace Michigan Medical Service as the largest Blue Shield Plan in the nation.

United Medical Service reached a total of 1,294,650 members on March 31, 1949, only a few thousand behind Michigan Medical Service with its 1,329,044 members as of the same date.

Although complete returns for the first quarter of 1949 have not been received by the Blue Shield na-

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*(Continued from Page 778)*

tional office, it is estimated that total membership in the nonprofit plans exceeded the 11,000,000 mark on March 31.

* * *

Advertisers in our JOURNAL are carefully selected. Only those meeting our advertising standards may use the facilities of our pages. No advertisement will be accepted which, either by intent or inference, would result in misleading the reader. May we suggest that you review the ads in each issue of our JOURNAL and, when occasion arises to prescribe products featured or use of the facilities offered; tell them you saw their ad in the MSMS JOURNAL.

* * *

*Michigan Authors.*—George R. Minor, M.D., Ann Arbor, Michigan, published a collective review, "Care of Patients with Surgical Diseases of the Chest," in *Surgery, Gynecology and Obstetrics* for March, 1948.

D. J. Leithauser, M.D., F.A.C.S., Detroit, Michigan, published an article, "Atypical Adynamic Ileus Apparently Caused by Nutritional (Thiamine Chloride) deficiency; Report of Six Cases," in *Surgery, Gynecology and Obstetrics* for May, 1948.

Max M. Peet, M.D., F.A.C.S., Ann Arbor, Michigan, Emil M. Isberg, M.D., Miami Beach, Florida, and Robert C. Bassett, M.D., Ann Arbor, Michigan, published an article, "Toxemia Superimposed upon Prepregnant Hypertension Treated by Splanchnicectomy," in *Surgery, Gynecology and Obstetrics* for June, 1948.

* * *

*Make a little notation* that seven industries are now "nationalized" in Britain. The latest one to become a function of the government is the gas (heating and lighting, not gasoline—which is called petrol, and not politics —which already is) industry. This transition was made with very little fanfare—proving that once the principle is established, it takes very little implementation to accomplish the change. And the June convention of the British Labor Party has as platform planks the "nationalization" of the insurance business and of all storage facilities. This is a good one for our insurance agents to mull over.—William Bromme, *Detroit Medical News,* May 16, 1949.

* * *

"If we understand this government medical insurance plan, it goes like this: When this plan is in effect, you have a headache, for instance; so the government pays for curing your headache. Then when you get the tax bill for the medical insurance, you have a worse headache. This used to be known as a vicious circle before Washington changed the name.—*Grand Rapids Press,* May 5, 1949.

*AMA Raises Standards of Graduate Medical Training.*—The American Medical Association announced on May 13, 1949, approval of a residency specifically designed to train *family doctors* and new requirements for approval of hospitals for intern training.

Previously the AMA Council on Medical Education and Hospitals had approved hospitals for general or mixed residencies, which were rather loosely organized training programs, for the purpose of providing additional experience following internship.

The residency for general practice will provide supervised training in the four major clinical divisions—internal medicine, surgery, obstetrics-gynecology, and pediatrics—as well as in the auxiliary services of anesthesiology, pathology, and radiology.

A total of 870 hospitals which the council had previously accredited for general residency training will be expected to reorganize their programs in accordance with the new requirements for the general practice residency. The American Medical Association emphasizes that the council's purpose is to encourage more young physicians to enter the field of general practice.

In the past doctors who did not intend to limit their work to a specialty have sought appointments to residencies in specialty fields because adequate facilities for a broader type of graduate training were not available, the editorial adds.

The council re-emphasized the importance of a well-organized program for intern training, stating that internships arranged merely to provide hospitals with resident personnel to assist in the clinical work of the hospital cannot be approved. It believes that a well-organized internship of the rotating type, which provides training in the four major clinical divisions, is likely to provide the best basic training for both the future general practitioner and the future specialist.

While the majority of internships approved are now of one year's duration, the council recommended longer periods of service.

For the first time, the council suggested a method for determining the number of interns to be appointed. The bed capacity of the hospital is used as a basis, with a range of fifteen to twenty-five beds per intern recommended. Although the council does not establish a specific number of interns to be appointed by approved hospitals, the hospitals will, no doubt, comply with this suggestion in organizing their programs, the editorial says.

Estimates indicate that 1,380 hospitals can meet the present quantitative requirements set up by the Council on Medical Education and Hospitals and hence have the potential to develop a program which will meet standards for approval by the council, according to the editorial. The number now approved for intern training is 807.

* * *

*Saginaw Valley Academy of Ophthalmology and Otolaryngology.*—At the Annual meeting May 10, 1949, at the Bancroft Hotel in Saginaw, Dr. Louis Dill, Detroit, talked on various aspects of nasal diseases. Dr. V. E. Cortipassi, Saginaw, was named president, and Dr. Wm.

Hubbard, Flint, was named president-elect. Dr. Andre Cortipassi was re-elected secretary-treasurer.

* * *

*Record Vote on Resolution Against Socialized Medicine.*—The following is the recorded vote of the members of the House of Representatives as they successfully adopted Senate Concurrent Resolution 19 which memorialized Congress not to pass legislation relative to socialized medicine. Scan this list to see how your local Representative(s) voted. *Congratulate them for a "yea" vote.*—If their vote was "nay" it indicates the need for them to be contacted with additional information on this important public question which should transcend party lines.

*Vote of Michigan Representatives*

*Yeas*

| | | |
|---|---|---|
| Acker | deBoom | Karel |
| Anderson | Decker | Kirk |
| Bannasch | Dickerson | Montgomery |
| Bauer | Engstrom | Morgan |
| Beardsley | Espie | Nelson |
| Benjamin | Estes | Peltz |
| Betz | Geerlings | Preston |
| Brigham | Graebner | Richards |
| Carroll | Haley | Schepers |
| Cavanagh | Hauffe | Storey |
| Christman | Hermann | Thomson |
| Cleary | Herrick | Van Valenburg |
| Conlin | Hoxie | Warner |
| Cramton | Hutchinson | Werner |
| Davidson | Johnston | Young, David E. |
| Deadman | | Speaker |

*Nays*

| | | |
|---|---|---|
| Carey | Harrelson | O'Brien, Michael J. |
| Chase | Hebert | O'Brien, Thomas C. |
| Collins | Kelly | O'Connor |
| Currie | Kowalski | O'Malley |
| Dingman | Lindsay | Penczak |
| Doll | MacKay | Ptaszkiewicz |
| Doyle, Leo J. | Mahoney | Rathke |
| Doyle, Patrick J. | McMahon | Sibley |
| Edwards, Miss | Morrison | Trombley |
| Fitzpatrick | Nill | Valenti |
| Fuller | Novak, Michael | Wilk |
| Griffiths, Mrs. | | Zanglin |

*Members Present and Not Voting*

| | | |
|---|---|---|
| Cooper | Novak, Stanley | Post |
| Kruse | Phillips | Robinson |

* * *

*Charles W. Buggs, M.D.,* who has been associated with the Wayne University College of Medicine since October, 1943, has become chairman of the Division of the Sciences and professor of biology at Dillard University in New Orleans, Louisiana. He will also serve as consultant in pre-medical education to a group of Negro institutions of higher learning. Dr. Buggs taught at Dillard for eight years before coming to Wayne University. While at Wayne, he has been associated with a number of research projects—notably, one on contaminated wounds and another on new penicillin preparations. His resignation from Wayne was effective April 9, 1949.

*Maternal Death Rate.*—Final tabulation of births and maternal deaths for 1947 by the National Office of Vital Statistics indicates a new record low maternal mortality rate of 1.3 per thousand live births. In 1933 the American rate of 6.2 placed this country eleventh among the leading nations. Since then the drop to 1.3, amounting to a 79 per cent reduction, has undoubtedly raised the rank of the United States to first place or close to first place. And this under our outmoded, inadequate system of health care!

* * *

*Official Statement of the Board of Trustees of the National Physicians Committee for the Extension of Medical Service.*—Ten years ago, a group of officers and fellows of the American Medical Association realized that the American Medical Association was not as active in certain functions as was deemed necessary, some of which seemed at that time inappropriate for the American Medical Association to perform. As a result, the National Physicians Committee for the Extension of Medical Service was created and has worked during these intervening years within the policies established by the House of Delegates of the American Medical Association.

Several times during those years, the House of Delegates has expressed confidence in the work of this organization.

Two years ago, a Committee of the House of Delegates reported that "the American Medical Association should and must do its own public relations work."

In December, 1948, the House of Delegates took action to create a new agency to carry on public relations activities and to further the extension of medical care. This new agency has been created and is functioning. The program as planned and now being carried on by the American Medical Association represents the fulfillment of the objectives for which the National Physicians Committee was created and toward which it has been working.

Its aims having been accomplished, the Board of Trustees of the National Physicians Committee met in Chicago on April 10, 1949, and voted (1) to approve the action of its Management Committee in authorizing cessation of all activities, as of April 1, 1949, and (2) to liquidate the affairs of the National Physicians Committee in an orderly manner.

It planned further to hold its next meeting in Atlantic City in June, 1949, and at that time to consider further action looking toward dissolution of the organization.

During its ten years of activity, the National Physicians Committee has brought about the formation of forty-seven state committees of physicians and forty-six state committees of dentists, in addition to other local organizations, that have functioned vigorously and well. The Board of Trustees now suggests to the physicians making up the personnel of these state committees that they offer their services to the new American Medical Association agency.—Edward H. Carey, M.D., *Chairman,* N.P.C. Board of Trustees.

*Orchids for MSMS:* M. A. Perlstein, M.D., Chicago, who recently conducted several cerebral palsy clinics throughout Michigan, writes: "The JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY is one of the best state medical journals that I have seen."

Dean Burns, M.D., Petoskey, Michigan, writes: "At a recent course of study at Bellevue Postgraduate in New York, I took great pleasure in hearing of the esteem in which the Michigan State Medical Society is held and of the respect with which its various pioneer activities are regarded, both in the postgraduate work it offers its members and in its approach to the economic problems of medicine. All of us realize that the major credit for the Society's outstanding reputation beyond the borders of the state must be given to its recent officers who have contributed so freely of their time and thought in the development of its program."

* * *

*J. S. DeTar, M.D.,* Milan, Speaker of the MSMS House of Delegates, spoke to the Saginaw County Medical Society on May 17 in Saginaw. His subject was "What Everyone Should Know About Socialized Medicine." The meeting was well attended by laymen.

* * *

*Three hundred and seven* was the total registration at the May 5 Ingham County Medical Society Clinic at the Olds Hotel, Lansing. The program included scientific talks by Donald R. Nichols, M.D., Rochester, N. Y.; Willard O. Thompson, M.D., Chicago; Priscilla White, M.D., Boston, and James J. Callahan, M.D., Chicago.

Elmer F. Hess, M.D., Erie, Pennsylvania, gave the dinner talk on "A Report from the Washington Scene."

* * *

*Hugh W. Brenneman,* Lansing, Public Relations Counsel for the Michigan State Medical Society, addressed the Medical Society Executives Conference in Atlantic City on June 8. His subject was "Co-ordinating the Work of State and County Medical Societies in Public Relations Activity."

Clem Whitaker and Leone Baxter, Public Relations Counsel for the AMA, spoke on "Status of the AMA Campaign."

* * *

*Life Magazine* of May 2, 1949, presented an illuminating editorial "Health by Compulsion" on Pages 40 and 41. The subtitle of this excellent analysis of the aims of the administration vs. that of the medical profession read "The President proposes much that is good, but there are better ways to achieve his goal."

Every doctor of medicine should read *Life's* editorial of May 2, which ends: "It is not the money, however, nor any threat of 'socialization,' that in the last analysis bothers *Life*. What worries us is the loss of moral power that must come when a people turns more and more to compulsion to solve its problems. Left to their own devices, the U. S. people have shown both ingenuity and ability in meeting their needs through voluntary action. Without state compulsion they have created the best medicine in the world. What is more, they have demonstrated that American capitalism can shape the social instruments necessary to a modern

society without relinquishing the freedom and responsibilities that make it strong."

* * *

*"Medicine and Politics Don't Mix"* is the title of an excellent editorial which appeared in *Collier's* May 14. This editorial says in part: "We think we shall get along faster and better if the advocates of better medical care for more people get this lurking desire for socialistic experimentation out of their heads. Some of it is there now to confuse the issue.

"We think it would be very wise for Congress to create a truly competent and unpolitical commission with which the doctors could in dignity co-operate. Out of such a group, comparable to the British Royal Commission, a truly statesman-like plan might evolve."

* * *

*"Medicine Man"* is the title of a report on socialized medicine in Great Britain, printed in *Time Magazine* of March 21, 1949. Five pages are devoted to this survey, including a lengthy biographical sketch of the champion of socialized medicine, Anuerin Bevan, Minister of Health, who "held arrogant and undisputed possession of the field when Churchill walked out of the house," according to *Time*.

* * *

*Lillian R. Smith, M.D.*, former director of the Bureau of Maternal and Child Health of the Michigan Department of Health, died at her home in Harwich, Cape Cod, Mass., on April 13. She retired from the Michigan Department of Health on June 30, 1946, after twenty-two years' service.

*The proportion of deaths from tuberculosis* among people over forty-five years of age is steadily increasing.—Robert J. Anderson, M.D., *Pub. Health Rep.*, April 1, 1949.

* * *

*Harry L. Clark, M.D.*, who has served Wayne University College of Medicine for almost forty years, has been appointed professor emeritus of bacteriology and clinical pathology.

* * *

*Action on Bills.*—H.R.4384, providing for the appointment of female doctors and specialists in the Medical Department of the Army, on June 6 was passed by the House of Representatives and sent to the Senate.

H.R.4567, displaced persons bill, passed the House of Representatives on June 2.

S.458, providing for a survey of physically handicapped citizens, was reported by the Senate Committee on Post Office and Civil Service with minor amendments on June 2.

* * *

*The National Committee for Chile* is now receiving gifts for the library of the medical school of the University of Chile at its new collection center in the Library of Congress, Washington. The newer materials in the library, including periodicals, books and reference materials, were totally destroyed in the recent fire. Medical periodicals of the last ten years and recent medical books are urgently needed. Your contribution will be appreciated. National Committee for Chile, Room 318, Library of Congress, Washington, D. C.

*United States Senator Butler* of Nebraska recently conducted a poll of 1,000 businessmen throughout the nation. This survey showed that these men are overwhelmingly opposed to the administration's compulsory health insurance proposal, Senator Butler said.

While 47 per cent favored and 53 per cent opposed extension of old age and unemployment benefits, *94 per cent opposed compulsory health insurance.*

* * *

*A Swindle.*—*"Socialized medicine in Britain* is a swindle, because we have not sufficient doctors, nurses, or hospitals to service the plan. One-ninth of the hospital beds are vacant because of lack of doctors and nurses."

"A crippled society (in England) is walking about on the crutches of capitalism. We are strengthening the weak by weakening the strong."—Cecil Palmer of England, in his famous address, "What Socialism is Doing to British Freedom."

* * *

*"In Tribute to the American Doctor"* is beautifully portrayed in the Philip Morris spread on pages 664 and 665 of this issue. Philip Morris invites you to send for a copy suitable for framing. Display it in your reception room—your patients will enjoy reading it."

* * *

*Past President Henry E. Perry, M.D.,* Newberry, is recovering from an automobile accident and can be reached by his many Michigan friends at the residence of his daughter, Mrs. Jean Langford, 907 Princeton Place, Lakeland, Florida.

* * *

*Wm. A. Hyland, M.D.,* Metz Building, Grand Rapids, as chairman of the Medical Advisory Committee of the American Cancer Society for Michigan, invites any doctor of medicine interested in cancer work to apply for fellowship grants from the Damon Runyon Memorial Fund, which is administered by the American Cancer Society. Applicants for the Fellowships can contact Dr. Hyland in Grand Rapids for this excellent opportunity.

* * *

*MSMS Secretary L. Fernald Foster, M.D.,* Bay City, presented the following talks, recently: Sebewaing Chamber of Commerce Meeting of March 28, "National Health Program"; Wayne County Medical Woman's Auxiliary, April 8, "Compulsory Health Insurance;" NBC network from Marinette, Wisconsin, on April 23, "Blue Cross and Blue Shield in Michigan."

* * *

*An open forum on* "Socialized Medicine" was held by the Kalamazoo Academy of Medicine at its April 19 meeting.

* * *

*The Bulletin of the Genesee County Medical Society,* issue of April 26, was a special edition edited by the Woman's Auxiliary to the G.C.M.S. It proved to be an interesting release.

* * *

*Under New Business,* the Executive Committee of the Ingham County Medical Society on April 5, 1949, adopted a motion urging "members of the Society to

prepare a motion withdrawing the former action of non-participation in Michigan Medical Service and as of this date that the Society urges its membership to become participating members in Michigan Medical Service."— From Ingham County Medical Society Bulletin, April, 1949.

* * *

*The Medical Film Institute* has opened offices in the New York Academy of Medicine Building, 2 E. 103rd St., New York City, according to an announcement of Walter A. Bloedorn, M.D., dean of George Washington University School of Medicine and chairman of the Audio Visual Committee of the Association of American Medical Colleges. The Institute was set up for the purpose of fostering high standards in medical film production as regards to scientific content, educational value, and cinematic qualities.

* * *

*The National Society for Crippled Children and Adults* will hold its convention November 7, 8 and 9, 1949, at the Commodore Hotel, New York, according to an announcement made from Chicago headquarters by Lawrence J. Linck, executive director. Delegates from 2,000 state and local affiliates of the National Society will discuss research, rehabilitation, training and treatment for the handicapped.

* * *

## ANNUAL COLLER-PENBERTHY CLINIC

The twenty-seventh annual Coller-Penberthy Clinic will be held in Traverse City on July 28-29, 1949, under the sponsorship of the Grand Traverse, Leelanau, Benzie County Medical Society.

This annual clinical teaching center has been constantly used by the Department of Postgraduate Medicine and the heads of the various departments of the University of Michigan Medical School as a testing group to institute and evaluate new ideas and techniques in extra-mural postgraduate medical teaching.

During the past two years a most successful development of a teaching program is the "Clinical Medical Conference" and the "Clinical Surgical Conference." Well-prepared patients are presented to a panel of experts, who request the history, examine and interrogate the patient, request laboratory and x-ray findings, and then discuss, out loud, amongst themselves the diagnostic and therapeutic problems. Audience participation in discussion follows, and the experts demonstrate diagnostic procedures. This ultra practical method of teaching the actively practicing physician has proven of great benefit, in that knowledge gained is associated with a definite patient, and thus memory is more retentive and useful for future use.

All doctors of medicine living or visiting in the Grand Traverse Region are invited to attend these two clinical days.

* * *

*An old Chinese saying:* "He that thinketh by the inch and talketh by the yard should be kicketh by the foot."

* * *

*Socialistic England* will exist as long as capitalistic America will let it.

* * *

# THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column, and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.*

PRACTICAL ASPECTS OF THYROID DISEASE. By George Crile, Jr., M.D., F.A.C.S., Department of Surgery, Cleveland Clinic. 355 pages with 101 figures. Philadelphia and London: W. B. Saunders Company, 1949. Price $6.00.

Since the turn of the century, the surgical treatment of goiter with the use of iodine has become a universally accepted course of action. Recently, the introduction of thiouracil has made a change and replaced the internist in the goiter field. Now many cases are being handled satisfactorily by the internist, with the radiologist. The prospect of radio-active iodine and its use is challenging. Dr. Crile gives a rather thorough, but small treatise on thyroid disease and its treatment, not neglecting the details of diagnosis, the exact operative procedures, the trials and dangers to be encountered. The disease is still a problem of the internist and other attendants, not just that of the surgeon. All must work together for the best results, and the outlook is encouraging for simpler methods. Many pictures, diagrams, and charts give invaluable information both for diagnosis and for selective treatment.

HANDBOOK OF DISEASES OF THE SKIN. By Richard L. Sutton, M.D., Emeritus Professor of Dermatology and Syphilology, University of Kansas Medical School; and Richard L. Sutton, Jr., M.D., Associate Professor of Dermatology and Syphilology, University of Kansas Medical School. With 1057 illustrations. St. Louis: C. V. Mosby Company, 1949. Price $12.50.

This is a very complete and excellently illustrated book. The pictures are clear, instructive and profuse. The text is well selected, well printed, but it seems to have much small print. All descriptions are in smaller type, while the text and discussion are large and easily readable. The complete field of dermatology is covered. Frequent references are given for source of the information given. This handbook is concise and a valuable reference.

SAFEGUARDING MOTHERHOOD. By Sol T. DeLee, M.D., Clinical Instructor of Obstetrics and Gynecology, University of Illinois; Attending Obstetrician at the Chicago Maternity Center; Former Associate in Obstetrics and Gynecology, Cook County Hospital. 42 illustrations. Philadelphia: J. B. Lippincott Company, 1949. Price $2.00.

This volume is written to inform the mother or expectant mother of the myriad things she should know. The information is exact, authentic, and seeks to answer the questions to be asked by the pregnant woman before they become a burden to the busy obstetrician. Dr. DeLee is seeking to forestall the many complications of

pregnancy which are due to ignorance or neglect. The expectant father also gets notice. A very handy book for the patient.

BLOOD TRANSFUSIONS. By Elmer L. DeGowin, M.D., Associate Professor of Internal Medicine, State University of Iowa: Robert C. Hardin, M.D., Assistant Professor of Medicine, State University of Iowa; and John B. Alsever, M.D., Senior Surgeon, U. S. Public Health Service. 587 pages with 200 diagrammatic drawings. Philadelphia and London: W. B. Saunders Company, 1949. Price $9.00.

The authors of this text covered the field of transfusion, placing special emphasis on the use of whole blood. The subject matter used is discussed briefly, but clearly and to the point. There are no long discourses on any particular phase. The high lights are emphasized with sufficient description and clarity.

In the beginning chapters the choice of blood and substitutes are given. Following this, there is a brief discussion of shock and the methods of treatment are outlined. The discussion of the various blood groups and types is admirably well presented, so that the pertinent facts are brought out. The descriptions are further emphasized by diagrams and graphs.

The chapter on laboratory procedure is outstanding, especially from the technician's standpoint, who now assumes such an important role in blood transfusions. Over 100 pages are devoted to this phase. The descriptions of the procedures are supplemented step by step by schematic diagrams, so that the processes can be easily followed without long explanations and descriptions.

The last part of the book is devoted to several chapters on the preparation, preservation, storage and administration of blood and its derivatives.

This is an excellent publication and should be read by all clinicians who are interested in transfusions. The transfusionist, pathologist and the technician will all do well to have this work in their libraries.

G.W.S.

OPERATING ROOM TECHNIQUE. By Adythe Louise Alexander, R.N., Supervisor of the Operating Rooms of the Roosevelt Hospital, New York City; formerly Supervisor of Operating Rooms, Mountainside Hospital, Montclair, N. J., Supervisor of Private Pavilion Operating Rooms, New York Hospital, New York City. With 668 illustrations. Second Edition. St. Louis: C. V. Mosby Company, 1949. Price $10.00.

The illustrations give pictures of every type of operation, showing various stages of the procedure, also the special instruments. The text is well set in large type, and describes briefly the operative procedure or objective, and gives the stages of the surgery, the layout of instruments, and a list as well as a picture of the finished layout. There is a discussion of the anesthetic, the position of the patient, draping, and a list of the procedures in 1, 2, 3, 4, 5 order, with in opposite columns a schedule of the instruments to be used. There is also a complete list of instruments, numbers of each, sutures, needles, sterile and other supplies, and a schedule of procedures up to twenty that we found in one condition. This is very complete, and could simplify the nurses' work in preparing for surgery. The text is also most informative for the surgeon also, to review all the steps he will take in some unusual case. Valuable and sufficiently compact.

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A FINE OPPORTUNITY exists for a Doctor of Medicine to build a practice in Romulus, Michigan, population 20,000. Office space is now available in the center of the business section. Only 15 miles from Detroit via fast expressway. Three hospitals conveniently located. Write: Porter Building, Box 576, Romulus, Michigan.

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## of the Michigan State Medical Society

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*Editor*
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

*Secretary and Business Manager of THE JOURNAL*
L. FERNALD FOSTER, M.D.
Thorne Bldg., 919 Washington Ave.
Bay City, Michigan

*Executive Director*
WM. J. BURNS, LL.B.
2020 Olds Tower, Lansing 8, Michigan

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 4, Minnesota, or 2020 Olds Tower, Lansing 8, Michigan. Telephone 57125.





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| Mason | J. C. Slaybaugh, Ludington | R. R. Scott, Scottville |
| Mecosta-Osceola-Lake | David Kilmer, Reed City | J. A. White, Big Rapids |
| Medical Society of North Central Counties | K. D. Coulter, Gladwin | S. A. Stealy, Box 485, Grayling |
| Menominee | J. R. Heidenreich, Daggett | H. R. Brukardt, Menominee |
| Midland | H. H. Gay, Midland | H. L. Gordon, Midland |
| Monroe | Florence Ames, Monroe | E. J. Sanger, 3 E. Front St., Monroe |
| Muskegon | J. L. Gillard, Muskegon | W. M. LeFevre, 289 W. Western Ave., Muskegon |
| Newaygo | J. P. Klein, Fremont | H. R. Moore, Newaygo |
| Northern Michigan | W. E. Larson, Cheboygan | L. E. Grate, Charlevoix |
| Oakland | E. B. Cudney, Pontiac | O. R. MacKenzie, Walled Lake |
| Oceana | W. A. Hasty, Shelby | C. H. Flint, Hart |
| Ontonagon | S. H. Rubinfeld, Ontonagon | W. F. Strong, Ontonagon |
| Ottawa | Otto Vander Velde, Holland | J. H. Kitchel, Grand Haven |
| Saginaw | W. K. Slack, Saginaw | M. J. Murray, 603 S. Jefferson, Saginaw |
| Sanilac | K. T. McGunegle, Sandusky | E. W. Blanchard, Deckerville |
| Shiawassee | Julius S. Janci, Owosso | W. L. Merz, Mason & Ball Streets, Owosso |
| St. Clair | H. C. Wass, St. Clair | E. W. Fitzgerald, Port Huron |
| St. Joseph | S. A. Fiegel, Sturgis | Eleanor M. Gillespie, Sturgis |
| Tuscola | H. L. Nigg, Caro | R. O. Flett, Millington |
| Van Buren | W. R. Young, Lawton | John Ralyea, Paw Paw |
| Washtenaw | F. B. Williamson, Ypsilanti | L. Dell Henry, 118 North State St., Ann Arbor |
| Wayne | J. J. Lightbody, Detroit | Charles J. Barone, 4421 Woodward Ave., Detroit |
| Wexford-Missaukee | R. V. Daugharty, Cadillac | G. C. Tornberg, Cadillac |

# You and Your Business

## HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

**Meeting of May 18, 1949**

- Monthly financial reports and bills payable were presented, studied and approved.
- The vital need for more space for the Executive Offices was again discussed. Six possible locations in Lansing have been inspected by the special committee (Drs. E. F. Sladek, T. E. DeGurse, and L. Fernald Foster). The committee was instructed to continue its survey and to negotiate for the rental or option to purchase a suitable property.
- Committee reports were approved from the Legislative Committee, the Sub-committee on Program for the 1950 Michigan Postgraduate Clinical Institute, the Medical Advisory Committee to The National Foundation for Infantile Paralysis, Uniform Fee Schedule for Governmental Agencies Committee, Committee on Co-operation with Blue Cross-Blue Shield, and the Special Committee on Education.
- The Public Relations Counsel's monthly report was presented, including script for the new MSMS movie as well as the fact that more organizations in Michigan have adopted resolutions against socialization of medicine than in any other state.
- Michigan Delegates to the AMA were present at this session to discuss ten items for possible presentation to the AMA House of Delegates in June, 1949.
- The Sub-committee on Diabetes (of the MSMS Geriatrics Committee) was authorized to include a statement in the next Secretary's Letter to Michigan's County Medical Societies regarding the Diabetic Detection Drive next autumn.
- The General Counsel presented opinions (a) on legal status of partnership for the practice of medicine, and (b) on matter of patient's consent for records.
- The Michigan Foundation for Medical and Health Education, Inc. was authorized to issue postgraduate diplomas or certificates to Fellow and Associate Fellows who have completed the prescribed course of study as outlined by the MSMS Committee on Postgraduate Medical Education in co-operation with the medical schools of the University of Michigan and of Wayne University.
- Report on annual visit to U. S. Senators and Congressmen (as authorized by MSMS House of Delegates) was reported by the MSMS representatives who visited Washington May 2-3. The delegation was thanked for its efforts in establishing a fine relationship between MSMS and our lawmaking friends in the national capitol.
- Councilor William S. Jones, M.D., of Menominee was given a vote of thanks for a splendid job in organizing a speaking tour throughout his 13th District in April; seven well-attended meetings, both public and medical, were addressed by President E. F. Sladek, M.D., and Secretary L. Fernald Foster, M.D.
- W. F. Strong, M.D., Ontonagon, was appointed chairman of the County Secretaries Conference of 1950.
- A Speakers Bureau Conference or public speaking "school" for doctors of medicine was authorized for September 22, in Grand Rapids, at the time of the MSMS Annual Session.
- A list of Past Speakers of the MSMS House of Delegates was authorized to be printed annually in the Handbook for Delegates.
- The Executive Committee of The Council, which convened at 11:00 a.m. adjourned after a full day at 9:10 p.m.

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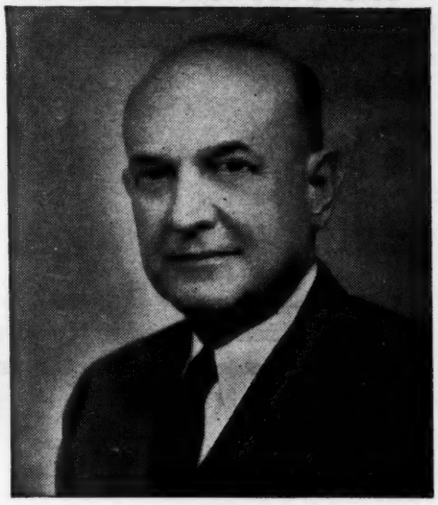
## REPORTS OF MEDICAL EXAMINATIONS FOR VETERANS ADMINISTRATION RATING AGENCIES

The National Rehabilitation Commission of the American Legion wishes to call to the attention of the medical profession that many veterans who are attempting to get disability claims adjudicated before Veterans Administration rating agencies are experiencing delays and handicaps in accomplishment of final rating because of physicians' reports and statements which are unsatisfactory or not acceptable to the Veterans Administration for one reason or another. The purpose of this statement

*(Continued on Page 802)*

FROM SECRETARY OF DEFENSE LOUIS JOHNSON—

# AN URGENT APPEAL TO YOUNG DOCTORS!



*Your personal help is needed to avert a serious threat to our national security!*

By the end of July of this year we will have lost almost one-third of the physicians and dentists now serving with our Armed Forces. Without an increased inflow of such personnel, the shortage will assume even more dangerous proportions by December of this year.

These losses are due to normal expiration of terms of service. The professional men who are leaving the Armed Forces during this critical period are doing so because they have fulfilled their duty-obligations and have earned the right to return to civilian practice.

Without sufficient replacements for these losses, we cannot continue to provide adequate medical and dental care for the almost 1,700,000 service men and women who are the backbone of our nation's defense.

***Normal procurement channels will not provide sufficient replacements!***

To alleviate this critical, impending shortage of professional manpower in the three services, I am urging all physicians and dentists who were trained under wartime A. S. T. P. and V-12 programs under government auspices or who were deferred in order to complete their training at personal expense, *and who saw no active service*, to volunteer for a two-year tour of active duty, at once!

We have written personally to more than 10,000 of you in the past weeks urging such action. The response to this appeal has not been encouraging, and our Armed Forces move rapidly toward a professional manpower crisis!

Many responses have been negative, but worse—a great number of doctors have not replied. It is urgent that we hear from you immediately!

*We feel certain that you recognize an obligation to your fellow men as well as to your profession in this matter. We are confident that you will fulfill that obligation in the spirit of public service that is a tradition with the physician and dentist.*

There is much to be said for a tour of duty with any of the Armed Forces. You will work and train with leading men of your professions. You will have access to abundant clinical material; have the best medical and dental facilities in which to practice. You will expand your whole concept of life through travel and practice in foreign lands. In many ways, a tour of service will be invaluable to you in later professional life!

*Volunteer now for active duty. You are urged to contact the Office of Secretary of Defense by collect wire immediately, signifying your acceptance and date of availability. Your services are badly needed. Will you offer them?*

Louis Johnson

## REPORTS OF MEDICAL EXAMINATIONS FOR VETERANS ADMINISTRATION RATING AGENCIES

*(Continued from Page 800)*

is to clarify what the Veterans Administration desires of physicians' reports to adjudicate claims properly. The Veterans Administration regulations require that the physician's statement be notarized only in initial establishment of service connection for a specific disease or condition. While this requirement is considered a waste of time by most physicians, it is a Veterans Administration requirement in establishing initial service connection. However, most doctors will be examining and working on reports for veterans who have already had service connection established, and are conducting the examination to determine whether the condition has improved, regressed or remained stationary. In such cases, the statement on the physician's letterhead is sufficient. Notarization is not required in these cases.

Since claims may be made months or, in some cases, years after the physician has examined or treated the veteran for a given condition, the doctor should state in the body of his report whether the information is from his office or clinic records, or from memory. Since Veterans Administration adjudication personnel have among their number physicians, or they can obtain the advice of Veterans Administration doctors, the reports should be in professional language with no attempt to simplify the terminology for lay interpretation. Interpretation of the validity of the doctors' data in relation to the veteran's claim will be made by medical personnel. Therefore the reports should be as complete and detailed as possible.

In the report, the date of first treatment and the length of time the veteran has been observed by the doctor should be included. Details of the pertinent history and physical examination are essential. The detailed medical findings, both physical and laboratory, should be included. For instance, degree of extension or flexion of an ankle may be very important in determining adjudication results. Such detailed medical findings should be listed by the reporting physician. When this is done, the final diagnosis made by the doctor can be interpreted in the light of the data that led to the making of the diagnosis. It is not sufficient merely to state that the veteran was treated for a given condition, without giving some of the pertinent facts relative to the condition in the particular veteran. If laboratory tests or roentgenologic or other special examinations are done, reports of these should be included, if such reports are available. Some of these data may be valuable to aid the Veterans Administration in establishing the merit of a veteran's claim.

In summary, the medical report for the veteran for adjudication purposes should be complete and as detailed as possible. History, physical examination, laboratory and special examinations, with dates of period of observation and performance of examinations, are desired. Only with such complete reports can justice to the claim of the veteran be done by the Veterans Administration adjudication agencies.

## VOLUNTARY HEALTH SERVICES

A great many organizations, both public and private, are active today in working toward better health. Furthermore, these organizations reach into every part of the country and offer a wide variety of services, according to a report just released by the Research Council for Economic Security, Chicago.

The Council's report, entitled "Roads to Better Health," points to public health and welfare organizations, military medical services, private medicine, prepaid medical care plans, and industrial programs as existing instruments with which to improve the health status of the nation.

Under public health and welfare programs, free hospitalization is available for the needy at state and county hospitals, which have a total of 817,000 beds throughout the country. In addition to hospitalization, medical care for low income groups is provided by federal, state, and local governments, and social agencies. About 5,000,000 persons currently use these facilities.

Another 120,000,000 persons receive medical care under private medical practice, either through the fee-for-service system or under one of the medical prepayment plans. The Council estimates that 56,000,000 persons are enrolled in prepaid hospitalization plans, 28,000,000 are covered by prepaid surgical benefits, and 13,000,000 are enrolled in prepaid medical plans. The army of private medical practitioners includes 170,000 physicians, 45,000 specialists, 435,000 nurses, and 83,000 dentists.

Industrial health programs for employes are another avenue to better health. Some 18,000 factories and business establishments provide industrial nurses, medical services, examinations, plant sanitation and hygiene. Employe benefit plans, offering protection to the worker on a voluntary basis, are rapidly increasing in volume and coverage. About one-half of the nation's total labor force, or 30,000,000 workers, are covered by workmen's compensation.

The Research Council, a nonprofit, nonpartisan organization, has been making studies in the field of health and social security since its inception four years ago.

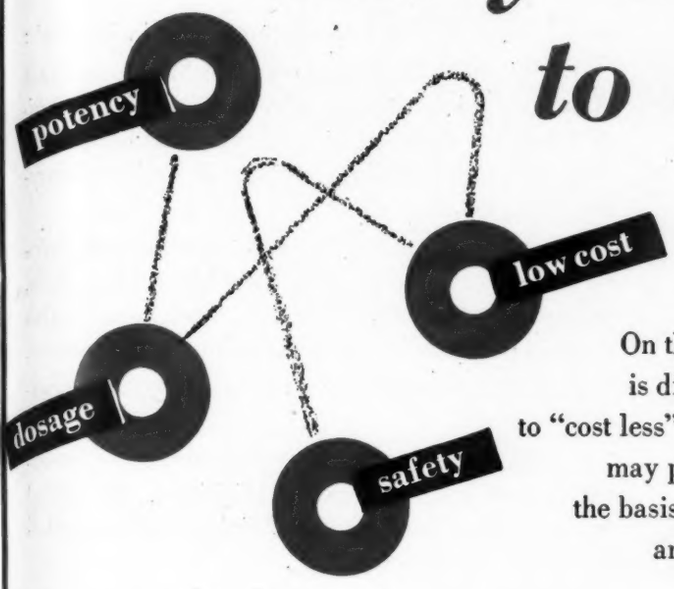
# Highlights from Under the Bushel

By L. W. Hull, M.D.

Chairman, Special Committee On Education

Top honors in this month's list of orchids for accomplishment go to the Bay County Medical Society! It has submitted to Lansing enough lists of "20" to qualify as the **first county group** to obtain names for 100 per cent of its membership . . . **Credit for this feat belongs to Bay County CAP chairman F. Pitkin Husted, M.D. and his top-flight salesman, Councilor Fred H. Drummond, M.D.** . . . Someone made the comment recently that "under socialized medicine, **pay-day** would really be **"pay" day** . . . R. C. Conybeare, M.D., Benton Harbor, has hit the speech circuit with a vengeance; he's made eight talks recently, with two groups passing resolutions against political medicine after he was finished . . . **The Copper Country sends word that Paul S. Sloan, M.D. of Houghton has over fifty-one names on his list of twenty** . . . Chairman of the Radio Committee for the Saginaw County Medical Society, Richard Ryan, M.D., has arranged for a series of broadcasts about socialized medicine over local station **WSAM** . . . **Another Saginawian, John E. Manning, M.D., has written personal letters to more than thirty-six Congressmen in Washington and already has received replies from most of them** . . . Still Saginaw; W. K. Slack, M.D., reports that Congressman Fred L. Crawford in a recent letter stated "that never before in his fourteen years in Washington has he seen so many well written, intelligent letters from constituents as are those written about socialized medicine" . . . **C. E. Umphrey, M.D., one of Detroit's Councilors, reports unusual success with the petition form he has on his wall. It reads, "If you prefer me to Uncle Sam, sign here"—the signers run into the hundreds** . . . Tuscola County Medical Society has been running a series of advertisements in local papers relative to socialized medicine—they report a good reception from readers . . . **In the last AMA publication of resolutions obtained from the forty-eight states, Michigan (like Abou Ben Adhem) led all the rest with 118 resolutions; New York was second, while some states failed to report a single resolution . . . By the time this reaches you, Michigan should have over 400 separate resolutions passed** . . . H. T. White, M.D., one of the dynamos in **Genesee County's** active program, has thrown out the suggestion that people might be impressed if all physicians were to operate for two weeks exactly as they would have to under a socialized system . . . **What is your thought?** . . . An active lay personality in CAP work is Mrs. Alice Diehl, Woman's Editor of the *Michigan Catholic.* Mrs. Diehl has written an excellent magazine article and is making talks before League of Catholic Women and Catholic Study Club groups . . . **Wayne County's CAP horizontal progress is being made under leadership of Alfred H. Whittaker, M.D., who heads the Inter-organizational CAP Committee. On May 17 he held a meeting with Detroit life insurance underwriters, dentists, druggists, lawyers, general insurance agents, health and accident insurance agents and others. Intensified action on part of all concerned resulted** . . . Upper Peninsula radio stations are devoting much free time for broadcasts of speeches made by physicians and field workers . . . **Special congratulations to H. V. Lilga, M.D., CAP chairman in Petoskey, for his letter-writing campaign to civic leaders in other cities. His work with the union labor ranks is also bearing fruit** . . . J. S. DeTtar, M.D., energetic physician, author and public speaker, delivered one of the principal addresses at the annual meeting of the Michigan State Pharmaceutical Association held early in June at Mackinac Island . . . The St. Joseph County Medical Society, with individual thanks to J. P. Sheldon, M.D., and S. A. Fiegel, M.D., can well be proud of the joint meeting held June 6 with the druggists, dentists and morticians in their county; the meeting brought promises of the closest of active co-operation between all these groups in the CAP program ahead . . . **Contributions for this column are requested** . . . **Let the Special Committee on Education hear of the work that you and your colleagues are doing . . . We'll tell others about your activities.**

# *many things to consider*




The choice of an oral estrogen depends on many factors—potency, dosage, safety and cost. On the basis of cost alone, a sound choice is difficult. An oral estrogen that appears to "cost less" may be wanting in potency; another may provoke troublesome side actions. On the basis of potency, however, the differences among oral estrogens are enlightening.

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*This extraordinary clinical activity has practical importance. It is characterized by virtual freedom from untoward reactions. Such low dosage obviously results in lower cost.*

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# Cancer Comment

## PROGRAM AND ACTIVITIES OF THE MICHIGAN CANCER CONTROL COMMITTEE

The Cancer Control Committee of the Michigan State Medical Society was first created in 1930 and for the next sixteen years consisted of seven members appointed annually by the incoming president. The committee met infrequently and served largely in an advisory capacity to those groups within the state interested in the cancer problem.

In 1935, the committee sponsored a state cancer survey by the American Society for the Control of Cancer (now the American Cancer Society, Inc.). The report of this survey, for the first time, summarized and analyzed the cancer problem in Michigan and suggested a program of education and clinical care in which the medical profession has the leading responsibility.

In 1943, in co-operation with the Michigan Department of Health, the "Cancer Manual for Physicians" was published and distributed to all members of the Michigan State Medical Society, medical health officers and other groups concerned with cancer in Michigan. This volume, written by Michigan physicians, created a wide interest in this country and in many foreign countries. It has been translated into several foreign languages.

In 1946, the membership of the Cancer Control Committee was enlarged to twenty-five and included representation from the Michigan Department of Health and the two Michigan Divisions of the American Cancer Society. A full-time medical secretary was appointed from among the membership and an office established at 1313 E. Ann Street, Ann Arbor. The committee's activities are financed by the four supporting organizations and by occasional contributions from other sources.

The committee, through subcommittees appointed by the chairman, considers problems in the field of cancer control related to Michigan. Lay and professional education, service to the cancer patient, medical examinations to detect cancer in early and curable stages, and similar problems command the committee's attention.

The following list of major activities of this committee, as at present constituted, is presented for the information of those interested in its work:

1. Provided all members of the Michigan State Medical Society with: (a) Volume I, *The Michigan Cancer Bulletin,* thirteen numbers; (b) Volume II, *The Michigan Cancer Bulletin,* twenty-one numbers.

2. Supplied the Michigan Cancer Program brochure—30,000 copies—to all Michigan physicians, dentists, pharmacists, hospitals, and local health departments for public distribution in their areas.

3. Provided speakers for many medical meetings.

4. Made cancer incidence and prevalence studies in four selected areas in Michigan. Published report of these studies. (See *Michigan Cancer Bulletin,* Vol II, Supplement).

5. Made a survey of Michigan hospitals to determine facilities for diagnosis and treatment of cancer, and also the number of cancer patients hospitalized in 1946. Published report of this study. (See JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, July, 1948, page 706.)

6. Assisted in organization of cancer detection centers in Michigan.

7. Surveyed cancer detection centers in Michigan in 1948. Published report of survey. (See JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, April, 1949, page 441.)

8. Assisted in development of the Hillsdale Plan for Tumor Detection which has aroused nation-wide interest as the best plan yet offered for making "Every Physician's Office a Cancer Detection Unit." Published description of plan and analysis of its first year's experience. (See JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, April, 1949, page 445.)

9. Helped promote a three-day cancer institute for public health officers and nurses at School of Public Health, University of Michigan.

10. Participated in the Inservice Training Course on Community Health Services at School of Public Health, University of Michigan.

11. Conducts a Cancer Comment page in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

*(Continued on Page 808)*

## PROGRAM AND ACTIVITIES OF THE MICHIGAN CANCER CONTROL COMMITTEE

*(Continued from Page 806)*

12. Sponsors an annual cancer number of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

13. Made studies of cancer reporting in the United States.

14. Will conduct a cancer teaching day for physicians following the 1949 annual meeting of the Michigan State Medical Society.

15. Later this year will hold a meeting of organizations in Michigan interested in cancer control to discuss the committee's statewide program of periodic medical examinations (The Hillsdale Plan) to detect cancer in early stages.

16. Provided broadcasts for Michigan radio networks.

17. Furnished speakers for many lay cancer meetings. Supplied outlines to many speakers.

18. Assisted in developing local cancer control programs.

19. Answered many telephone and written requests for information about cancer from Michigan and other states.

20. Stands ready to assist in development of cancer education and control programs in any part of Michigan.

---

A slow or incomplete recovery from an acute respiratory infection, especially in a male between the ages of forty and seventy, may be the first indication of bronchogenic cancer.

• • •

A transient wheeze accompanies primary cancer of the lung in 10 to 15 per cent of patients.

• • •

Weight loss is a frequent companion of pulmonary carcinoma.

• • •

Dyspnea and pleural effusion are associated with local invasion of the pleura in lung cancer.

• • •

Neurological symptoms suggestive of a primary brain tumor may be the presenting signs of a bronchogenic carcinoma.

• • •

Positive histological evidence of malignancy is obtained in 42 to 62 per cent of all cases of lung carcinoma.

• • •

Cough is the first symptom in over half the cases of pulmonary carcinoma.

• • •

The physician who "watches" that "something" in the patient's lung often watches the patient die.

• • •

Carcinoma of the lung occurs five times more frequently in men than in women.

• • •

Increase in the five-year survival rate can and will be effected when full use is made of existing diagnostic techniques—when every person with "something" in his chest is given the benefit of a thorough and complete examination, pursued until the physician can state unequivocally and without reservation that the patient does not have any evidence whatsoever of pulmonary cancer.

# Resolution re A.V. Wenger, M.D.

Forty-six years of unbroken attendance at the annual sessions of the Michigan State Medical Society were recognized at the eighty-third session held in Detroit last September when an appropriate resolution was tendered to Aaron Verne Wenger, M.D., Grand Rapids surgeon, by the Michigan State Medical Society House of Delegates.

In addition to the perfect attendance record, Dr. Wenger was honored for his more than thirty-one years as a member of the Michigan State Medical Society House of Delegates.

Dr. Wenger, who was born in 1877, received his medical degree from the Grand Rapids Medical College in the year 1901. He began his practice in the same year.

The resolution to Dr. Wenger read as follows:

"WHEREAS, A. V. Wenger, M.D., has established a record of unbroken attendance at the meetings of the Michigan State Medical Society since 1902, a period of forty-six years, and

"WHEREAS, Doctor Wenger has served the State Society as a Delegate of Kent County continuously from 1917 to date, a period of thirty-one years, and

"WHEREAS, Over this period his effort has been without recompense, therefore be it

"RESOLVED, That this House formally recognize such unselfish and understanding effort in behalf of medicine and the physicians of Michigan by hereby expressing its gratitude to Doctor Wenger and further be it

"RESOLVED, That the Secretary be instructed to advise Dr. Wenger of this action and that the publication of this record be made in THE JOURNAL of the Society in a prominent position."

# PR In Practice

## SPEAKERS BUREAU

The following names have been added to the list composing the MSMS Speakers Bureau as published in last month's JOURNAL.

*Gratiot-Isabella-Clare*

E. S. Oldham, M.D., Breckenridge
L. L. David, M.D., Mt. Pleasant
Kuno Hammerberg, M.D., 622 McEvan, Clare

*Kent*

John R. Pedden, M.D., 1144 Madison, Grand Rapids
James Ferguson, M.D., 72 Sheldon, S.E., Grand Rapids
C. Allen Payne, M.D., Blodgett Memorial Hospital, Grand Rapids
Fred C. Brace, M.D., 1498 Lake Drive, S.E., Grand Rapids
John R. Olson, M.D., Medical Arts Bldg., Grand Rapids
Wm. A. Hyland, M.D., Metz Bldg., Grand Rapids
A. B. Smith, M.D., Metz Bldg., Grand Rapids
W. C. Beets, M.D., Loraine Bldg., Grand Rapids
Wm. R. Torgerson, M.D., Metz Bldg., Grand Rapids
Howard Benjamin, M.D., 514 Medical Arts Bldg., Grand Rapids
Paul Kniskern, M.D., Medical Arts Bldg., Grand Rapids

*Mecosta-Osceola-Lake*

Edward VanAuken, M.D., Big Rapids
G. H. Yeo, M.D., 126 Maple St., Big Rapids
J. A. White, M.D., 121 S. Michigan Ave., Big Rapids

*Oakland*

Robert Baker, M.D., 1110 Pontiac State Bank Bldg., Pontiac
Otto Beck, M.D., 308 Wabcek Bldg., Birmingham
Joseph Christie, M.D., 1201 Pontiac State Bank Bldg., Pontiac
O. R. MacKenzie, M.D., 128 Common St., Walled Lake

*St. Joseph*

S. Albert Fiegel, M.D., 110 Pleasant St., Sturgis
R. J. Fortner, M.D., 218 East St., Three Rivers
E. M. Gillespie, M.D., 104 W. Chicago, Sturgis
R. A. Springer, M.D., 125 Market, Centerville
R. Zimont, M.D., 100 S. Washington, Constantine
N. B. McGrath, M.D., 226 East St., Three Rivers
J. P. Sheldon, M.D., S. Clay, Sturgis

*St. Clair*

Walter Boughner, M.D., Algonac
J. L. Sanderson, M.D., 515 Pine St., Port Huron

# Socialized Medicine

## FREEDOM BEST IN MEDICAL FIELD

Freedom works best, whether it is in the economic field or the medical field. The countries that have kept their doctors free of governmental control, America, Norway, Sweden and Denmark, have the best health records of all the nations in the world.

If we in America are going to try to improve our health standards even more, the best way is to do it through some method that prevents the federal government from controlling the medical profession.

Eugene C. Pulliam, publisher of *The Star,* described in Friday's article from Copenhagen the way in which Norway, Sweden and Denmark have provided medical facilities for all their people without federal control and without government insurance. These countries have "the best public health programs in the world." The reason they do is because their doctors have been kept free.

While the three countries differ in some of the details of the public health programs, they all agree on one point. Those who can pay for medical care do so through private, government-approved insurance companies. Those who cannot pay (in Denmark and Norway that includes those who earn less than $2,000 a year), are automatically covered through private insurance with government aid.

Plans similar to these Scandinavian health programs have been proposed in several bills introduced in the United States Senate. Both Republicans and Democrats have sponsored them. They all provide for voluntary, private insurance programs and they all cover those who cannot afford to pay themselves.

They also provide needed help in enlarging the number of doctors and hospitals in the United States, which has to be done if we are to extend the benefits of our already advanced medical care programs to more people.

If Congress is going to learn from the experience of others in devising a better public health program in the United States, the place to learn is from the successful, and not from the unsuccessful.

Germany tried socialized medicine and ruined its medical system.

Britain is trying it, and British doctors are bogged down with red tape and hordes of patients.

The Scandinavian countries have based their health programs on liberty and have set an example of outstanding success that we would do well to follow.—*Indianapolis Star,* May 8, 1949.

## COMPLETE LIST OF ORGANIZATIONS IN MICHIGAN WHICH HAVE PASSED RESOLUTIONS OPPOSING SOCIALIZED MEDICINE

All County Medical Societies
All County Woman's Auxiliaries
Bay City Chamber of Commerce
Birmingham Chamber of Commerce
Caro Board of Commerce
Chamber of Commerce of Fremont, Michigan
Dearborn Chamber of Commerce
Detroit Archdiocesan Council of Catholic Women
Detroit Business Woman's Club
Detroit Sorosis Club
Easton Community Farm Bureau, Ionia County, Michigan
Evangeline Home and Hospital Staff, Grand Rapids
Flint Chamber of Commerce
Genesee County Dental Society
Greater Jackson Association Board of Directors
Houghton Rotary Club
Isabella-Clare Counties Automobile Dealers Association
Ishpeming Rotary Club
Kalamazoo Chamber of Commerce
Lansing Life Underwriters
Larned Post No. 1, American Legion
Legislature of the State of Michigan
Metropolitan Club Auxiliary (East Detroit Chapter)
Michigan Association of Collection Agencies, Inc.
Michigan Chiropody Association
Michigan Hospital Association
Michigan Junior Chamber of Commerce
Michigan Postgraduate Clinical Institute
Ontonagon Chamber of Commerce
Port Huron Chamber of Commerce
Republican State Convention
Royal Oak Chamber of Commerce
United Daughters of Confederacy
Wayne County Womens Republican Club
Westminster Presbyterian Woman's Church Group (Detroit)
Wyandotte Republican Woman's Club

## "NOTHING FOR SOMETHING"

Cyril Palmer, noted London editor, has this to say: "The British experiment in socialized medicine is an unfortunate swindle from start to finish. This is so because it pretends to offer something for next to nothing, and actually gives nothing for something."